Indiana University South Bend
Heath & Wellness Center

Patricia Kelly-Holmes
M.D.

1700 Mishawaka Ave., South Bend, IN 46634
Phone: 574-520-5557 Fax: 574-520-5042

AUTHORIZATION TO RELEASE/DISCLOSE HEALTHCARE INFORMATION

I, _____, hereby authorize:

Name/Agency _____
Address _____
City _____ State _____ Zip Code _____
Phone (____)_____ Fax (_____)_____

AND

Indiana University South Bend
Health and Wellness Center
1700 Mishawaka Avenue, SAC 130P
South Bend, IN 46634
Phone; (574) 520-5557; Fax: (574) 520-5042

To release and exchange healthcare information with each other. This request and authorization applies to:

□Healthcare information relating to the following treatment, condition, or dates:

_____

□ All healthcare information.

□Other:_____

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

I understand that I may revoke this Authorization in writing except to the extent action has been taken in reliance thereon. If revoked, it is understood by all affected parties that all health information released prior to being notified of such revocation was made with my authorization. The request shall remain valid until revoked or upon expiration of ninety (90) days, whichever occurs first.

Printed Name: _____ Date of Birth:_____ Patient Signature: _____ Date Signed: _____	Printed Name: _____ Administrator: _____ Date Signed : _____