



The **Indiana**
Orthopaedic
Center

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Philip C. Sailer, M.D.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____/_____/_____
(Patient's Name) (Patient's Date of Birth)

(Street Address, City, State, & Zip Code)

(317) (317) (317)
(Home Phone) (Cell Phone) (Alternate)

The undersigned hereby authorizes The Indiana Orthopaedic Center to release the following portions of the medical records of the above named patient for the following purpose:

Entire medical record for the period of _____ to _____.

_____ X-Ray Films for the period of _____ to _____.

Release to: _____ (Facility Name) _____ (Attention)

(Street Address, City, State, Zip Code)

(317) (317)
(Phone) (Fax)

I, the undersigned, understand that I may REVOKE this authorization at any time, in writing, but the request shall remain valid until revoked or upon the expiration of sixty (60) days, whichever occurs first, EXCEPT to the extent that action has been taken thereon. I understand that I am giving permission to release medical information which may include treatment for physical therapy and/or emotional illness, communicable diseases, alcohol or drug abuse treatment, and/or HIV, AIDS, or AIDS-related information.

_____, 2010
(*Signature as designated by law) (Date of Signature)

Relationship (if other than the patient)

EAST
1400 N. Ritter Ave., Suite 351
Indianapolis, IN 46219
317-588-2663
317-355-1179 FAX

NORTH-CORPORATE OFFICE/MEDICAL RECORDS
7930 N. Shadeland Ave.
Indianapolis, IN 46256
317-588-2663 x277
317-863-2276 FAX

GREENFIELD
1 Memorial Square, Suite 115
Greenfield, IN 46140
317-588-2663
317-462-4696 FAX

NOBLESVILLE
14540 Prairie Lakes Blvd. N #351
Noblesville, IN 46060
317-863-2215
317-773-4877 FAX

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