

REPRODUCTIVE CARE OF INDIANA
201 Pennsylvania Parkway, Suite 310; Indianapolis, IN 46280
317-817-1800 ~ Fax 317-817-1810

**Patient authorization for copy and release of medical records to Reproductive
Care of Indiana**

I, _____
(Name of Patient)

(Address of Patient)

_____ (Date of Birth) _____ (SS #)

Hereby authorize Reproductive Care of Indiana to **obtain copies of my health information from:**

(Name and complete address of healthcare provider)

(Phone and Fax Number)

Portion of protected health information record requested:

_____ Complete medical record

_____ Partial medical records- specific records requested includes

Please forward medical records to:
Michael A. Henry, MD
Reproductive Care of Indiana
201 Pennsylvania Parkway, Suite 310
Indianapolis, IN 46280
317-817-1800
317-817-1810 FAX

Patient Signature: _____ Date: _____