



# IU Health Physicians

*James E. Lingeman M.D., FACS*  
*Ronald E. Steele M.D., FACS*  
*Christy B. Krieg, N.P.*

*Larry C. Munch M.D., FACS*  
*Ronald S. Boris, M.D.*

*Phone 317.962.3700*

Due to HIPAA regulations, in order to release any healthcare or billing information to any other person besides the patient, we must have this signed authorization form on file.

Patient Name (print) \_\_\_\_\_ DOB \_\_\_\_\_

I hereby authorize IU Health Physicians to use or disclose my identifiable health information, both medical and billing, as described below. I understand this authorization is voluntary. I understand that if the organization or persons authorized to receive the information is not a health plan or health care provider, the release information may no longer be protected by federal privacy regulations.

Please list below any persons other than yourself or your medical providers that we may release any healthcare or billing information to. If there is no one, please leave this section blank.

Name \_\_\_\_\_

Relationship \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Name \_\_\_\_\_

Relationship \_\_\_\_\_ Phone ( ) \_\_\_\_\_

I understand that I will not be denied healthcare or health plan coverage, as the case may be, if I do not sign this form. I understand that I may see and copy the information described on this form if I ask for it, and that I may request a copy of this form after I sign it. I understand that I may revoke this authorization at any time by notifying the person or organization and providing the information in writing, but doing so will not effect any actions taken prior to the revocation being received.

Signature \_\_\_\_\_ Date \_\_\_\_\_

(For office use only) Revocation Date \_\_\_\_\_ Signature \_\_\_\_\_

### **HIPAA Privacy Notice Acknowledgement**

Copies of our Privacy Policy are located in our office, you may request a copy for your records from our receptionist.

I acknowledge that a copy of the Notice of Privacy has been made available to me.

Signature \_\_\_\_\_ Date \_\_\_\_\_

### **Indiana Clinic Urology Financial Policy**

Copies of our Financial Policy are located in our office, you may request a copy for your records from our receptionist.

I acknowledge that a copy of the Financial Privacy has been made available to me.

Signature \_\_\_\_\_ Date \_\_\_\_\_