BLOOM
HEALTH & WELLNESS

RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

Patient's Name: _____ DOB: _____

Address: _____ Phone: _____

I hereby authorize Bloom Health & Wellness to RELEASE protected healthcare information of the person above to the following entity:

☐ Myself

☐ Another healthcare provider/organization:

Hospital/Office Name: _____

Address: _____ City/State/Zip: _____

Phone: _____ Fax: _____

I hereby authorize Bloom Health & Wellness to REQUEST protected healthcare information of the person above from the following entity:

Hospital/Office Name: _____

Address: _____City/State/Zip: _____

Phone: _____ Fax: _____

Record Preference: ☐ Electronic Message ☐ Paper (out-going requests of >100 pgs will be electronic)

☐ Problem List & Med List ☐ Mammo/Pap/Colon ☐ Billing information

☐ Last 2 years of office visits ☐ Last Two Year(s) of Labs and Diagnostic Tests

☐ Other: _____ ☐ Dates: _____

***Mental/behavioral health and substance use records require a separate Authorization for Release**

Reason for Disclosure:

☐ Continuation of Care/Transfer of Care ☐ Workman's Compensation ☐ Attorney/Legal

☐ Insurance Company ☐ Other: _____

_____**Are you sending your records to establish a NEW primary care provider? If yes, please initial** to acknowledge that once your medical records have been transferred to another office you will no longer be considered an ACTIVE patient at Bloom Health & Wellness.

I understand that I may revoke this release at any time in writing. This request shall remain valid until revoked or upon the expiration of sixty (180) days, whichever comes first. I also understand that the records released/requested may incidentally include information on alcohol and/or substance abuse information, HIV/AIDS, and/or STI history. **I understand that it will take at least 48 business hours to process this request. You may send this request to Bloom Health & Wellness fax 812-992-1002.**

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

☐Patient Identification Verified by (initials)_____ Printed/Faxed/Mailed on Date:_____

☐Documents picked up by: _____ Patient ID verified by:_____

THIS REQUEST SERVES AS A LEGAL AND BINDING DOCUMENT

Created 2/2026