

Holm Medical Clinic
2855 Miller Drive, Suite 117
Plymouth, IN 46563
574-936-7777
Fax 574-941-1072

Patient's full name: _____ SSN: ____ - ____ - ____ DOB: ____ / ____ / ____

Reason for request:

- Medical (Continuing Care)
- Medical (Transferring Care)
- Health Insurance
- Life/Disability Insurance
- Legal
- Personal
- Other

Reason for change (if changing locally)

- Insurance change to _____
- Dissatisfied with current medical practice
Reason: _____
- Other _____

Information to be released

- Complete Record
- Partial Record
- Do not send any information relating to AIDS,ARC, or HIV
- Do not send any information relating to alcohol or drug abuse
- Do not send any information relating to mental health disorders

Dates Requested -
from ____ / ____ / ____ to ____ / ____ / ____

I, _____, certify the above request is accurate and hereby
Authorize the release of the medical records specified above.

Signature of Patient (or Guardian for Minors) ____ / ____ / ____ _____
Date of Authorization Phone Number

RELEASE INFORMATION FROM:

Phone _____ fax _____

RELEASE INFORMATION TO:

Holm Medical Clinic
2855 Miller Drive, Suite #117
Plymouth, IN 46563

Patients requesting a permanent transfer of records or copies for personal reasons may incur a charge. **Record Copy Fee.** Minimum charge is \$10.00 or \$1.00 for 1st 10 pages, \$0.50 per page for pages 11-50, and \$0.25 for each page in excess of 50.