



INDIANA STATE NURSES ASSISTANCE PROGRAM
 2915 N. High School Rd., Indianapolis, IN 46224
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 www.IndianaNurses.org

RECORDS REQUEST

DATE: _____

NAME: _____

DOB: _____

HOME#: _____

CELL #: _____

INFORMATION TO BE RELEASED (Please "X" all to be released)

- | | |
|---|--|
| <input type="checkbox"/> AA/NA and NSG Meeting Logs | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Addictionist | <input type="checkbox"/> Recovery Monitoring Agreement and Addendums |
| <input type="checkbox"/> Assessment | <input type="checkbox"/> Self-Reports |
| <input type="checkbox"/> Attorney General's Office | <input type="checkbox"/> Sponsor Reports |
| <input type="checkbox"/> Correspondence | <input type="checkbox"/> Therapist Reports |
| <input type="checkbox"/> Intake Information | <input type="checkbox"/> Treatment Facility |
| <input type="checkbox"/> Medical Information | <input type="checkbox"/> UDS Reports – Dates _____ |
| <input type="checkbox"/> Prescriptions | <input type="checkbox"/> Work Site Monitor(s) Reports |

INFORMATION TO BE RELEASED TO:

Name: _____

Agency: _____

Address: _____

City, State, Zip: _____

Phone#: _____

Fax#: _____

To Be Released On Or Before Date: _____

Your Signature: _____

Today's Date: _____

CONFIDENTIALITY NOTICE:

Any record in ISNAP's possession that is labeled "confidential" will NOT be released to anyone. You will have to get those records from the provider.

This is NOT a 'standing' release. If the information is to be released monthly a new release form will need to be done every month.

*Please allow up to 14 days after receipt of request to have the information released.
 A fee may be charged to the participant for anything over 10 pages.*