Payne Nursing Services, LLC

Authorization for the Release of Medical or Behavioral Information

Patient Name: _____

Patient DOB: _____ Patient SSN: _____

Patient Phone: _____ Patient Phone, alternate: _____

Patient Address: _____

_____

This information is to be used for communication and exchange of information between:

Payne Nursing Services, LLC		Name:
5999 W Memory Ln		Address:
Greenfield, IN 46140	AND	
Phone: 317-779-1204 Fax: 317-940-5459		Phone: Fax:
Email: FrontDesk@PayneNursing.com		Email:

I voluntarily authorize Payne Nursing Services, LLC (PNS) to disclose **and/or** receive confidential information to the above individual(s) and I authorize the release of protected confidential information regarding the following (**please initial**)

___ Mental Health ___ Substance Abuse ___ HIV/AIDS

May release all records____ or specify those to be released by marking below:

___Psychiatric Evaluation/Consultation

___Psychological Testing

___School Records

___Lab Reports

___Child In Need of Assistance Records

___Discharge Summary

___Assessment/Intake

___Therapy Notes

___Medical Records

___In-home Counseling Notes

___Psychosocial History

___Other: Patient Information

This information is being disclosed and may be used only for the following purpose(s):

____ Other: (please specify) _____

____ Coordination of services_____

____ Continuation of Care _____

Authorization for release of information is effective for 12 months from date of signing

OR You may specify one of the following:

_____Authorization for obtaining records is for the records dated from: _____ to _____

_____All time; all past, present, and future records

If I am requesting this Authorization from you for my own use and disclosure or to allow another health care professional or health care entity to disclose information to me or the parties named above: (1) You cannot deny your services or treatment to me if I refuse to make this signed authorization; (2) I have the right to inspect a copy of the protected health information to be used or disclosed. Except where it applies under IC 16-39-2-4; (3) I may refuse to sign this Authorization; and (4) I must provide you with a copy of the signed authorization. I have the right to revoke this authorization at any time, provided that I do so in writing and except to the extent that you have already used or disclosed the information in reliance on the authorization. By signing this authorization, I may be directing you to disclose my health information to a person or organization that does not have the same obligations to protect privacy as required of health care practitioners, health plans and other health care entities observed under state and federal law. The disclosure of the information specified above may carry with it the potential for unauthorized disclosure of my protected health information and loss of protection under state and federal law. I may request that you require the recipient of my protected health information to sign a confidentiality agreement in which the recipient agrees to limit use and disclosure of my information as specified by the confidentiality agreement. If the intended recipient refused to sign the confidentiality agreement I requested, you would not have to release the information.

Today's Date _____

Patient's Signature _____

Patients Printed Name _____

Legal Representative Printed Name _____

Legal Representative Signature _____

Relationship to Patient _____

PROHIBITION FOR REDISCLOSURE:

This information has been disclosed to you from records whose confidentiality is protected by Federal and/or State Law. The Authorization for Release of Information form does not authorize re-disclosure of medical information beyond the limits of this consent. Federal Law (42 U.S.C. 290dd-2) for Alcohol/Drug abuse and State Law (Indiana IC 16-39) for Mental Health, and HIV/AIDS treatment, prohibit information disclosed from records protected by these laws from being re-disclosed, even to the patient without the specific written consent of the patient or as otherwise permitted by such laws and/or regulations. A general authorization for the release of medical or other information is **NOT** sufficient for these purposes. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. Civil and Criminal Penalties may be attached for unauthorization disclosure of alcohol/drug, mental health, or HIV/AIDS information.

Version	Date of Update	Changes	Updated By
2	11.30.2024	Added footer, page number with counts, changed spacing, and changed font to Candara. Adjusted signature lines. Corrected verbiage for dates of records to be obtained.	C Payne
3	07.21.2025	Added clarifying line for ROI effective dates	C Payne
4	08.20.25	Review for 2025, no changes.	C Payne