**Authorization for Release of Information**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* I hear by voluntarily authorize and consent to disclosure of health records and/or information as stated below. This information can be released by phone, fax, or mail.
* I understand that I may refuse to sign this authorization, and that my refusal will not affect my ability to obtain services, treatment or payment of services; unless services provided are solely to create health records for a third party, such as for an insurance company.
* I understand that I may see or receive a copy of the information described in this form if I ask for it and that copy fees will apply as allowed by State Law.
* Unless limited below, I understand that this release also pertains to records whose confidentiality is protected by either federal regulations (42 CFR Part 2) or State Law (IC16-39-2) concerning hospitalization or treatment, included to but not limited to, information regarding treatment and related services for alcohol and/or substance abuse, medical disease documentation, human immunodeficiency virus (HIV), or for mental health treatment or counseling.

I authorize Center for Assessment and Therapy to release/obtain information to/from the following:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Information to be released: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Purpose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Substance Abuse Records Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_

* I completely waive and release any rights of confidentiality I may have concerning these records and information, and agree to hold the therapist or staff of this practice harmless and to indemnify the staff from any and all claims made in connection with release of these records and information as here authorized.
* I understand this authorization is only valid for 60 days unless otherwise noted. I have the right to revoke except if Center for Assessment and Therapy have taken action and reliance upon us authorization or is this authorization was given as a condition of obtaining insurance coverage. Center for Assessment and Therapy may charge a designated recipient the maximal allowable by law. Reasonable notice is required regarding notification disclosure of Protected Health Information.

Signature of Client Printed Name Date

Signature of Parent/Guardian Printed Name Relationship Date

I witnessed that the person understood the nature of this request/authorization and freely gave his or her consent.

Signature Witness Printed Name Date

I may revoke this authorization by submitting a written revocation to 15 Moore St. Mooresville, IN 46158.