Indianapolis Trauma Therapy Center

Trauma and Attachment Therapy
Psychotherapy, Consultation, Training

AUTHORIZATION TO RELEASE MENTAL HEALTH TREATMENT INFORMATION

I, _____(Name of Patient/Client), whose Date of Birth is _____, authorize Indianapolis Trauma Therapy Center and its associates to disclose to and/or obtain from: _____ (Name of Person/Organization)

the following information:

Description of Information to be Disclosed (Please initial each item to be disclosed)

_____ Assessment

_____ Diagnosis

_____ Psychosocial Evaluation

_____ Psychological Evaluation

_____ Psychiatric Evaluation

_____ Treatment Plan or Summary

_____ Current Treatment Update

_____ Medication Management Information

_____ Presence/Participation in Treatment

_____Nursing/Medical Information

_____ Educational Information

_____ Discharge/Transfer Summary

_____ Continuing Care Plan

_____ Progress in Treatment

_____ Demographic Information

_____Other_____

_____Psychotherapy Notes* (*Cannot be combined with any other disclosure)

Purpose The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

Revocation I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to _____ at Indianapolis Trauma Therapy Center. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration Unless sooner revoked, this authorization expires on the following date: _____ or as otherwise indicated:_____

Conditions I further understand that Indianapolis Trauma Therapy Center nor its associates will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences:

_____

_____

Form of Disclosure Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I will be given a copy of this authorization for my records.

_____

Signature of Patient/Client Date

_____

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.)

Refusal of Authorization_____

_____

Signature of Staff Witness Date