Release of Information Form

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Full Name

First Name Last Name

Date of Birth

Month Day Year

- I authorize the use or disclosure of the above named individual's health information as described below.
- The following individuals or organizations are authorized to exchange information:

(I) The Growth Center

4925 Charlestown Rd.

New Albany, IN 47150

Phone: 812-941-9200

Fax: 812-941-9205

(II) Additional Release Info To/From:

Name

First Name Last Name

Business Name

Address

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Phone Number

Area Code Phone Number

Fax

Area Code Phone Number

I authorize The Growth Center (I) to exchange information with the business, person or persons in item (II.)

- ◯ YES
- ◯ NO

1. PURPOSE for health info disclosure (check those that apply):

*

- ☐ Continuity of Care
- ☐ Return to Work
- ☐ Legal Proceedings
- ☐ School Assignment
- ☐ Disability Renewal/Application
- ☐ Treatment/Billing Coordination
- ☐ _____

2. SPECIFIC INFORMATION requested to be disclosed (check those that apply):

*

- ☐ Entire Admission History/Medial Records including: patient histories, office notes (except psychotherapy notes and records received from other health care providers), personal information, billing and insurance records.
- ☐ Medical Records
- ☐ Billing, Insurance, Tx Dates, Demographic Info
- ☐ Psychiatric Evaluation Only
- ☐ Treatment Summary
- ☐ _____

3. HOW would you like the information disclosed (check those that apply then initial below):

*

- ☐ Speak w/ Person:
- ☐ Letter, explain
- ☐ Form, explain
- ☐ _____

Who? (Name/Relationship)

_____

John Smith/Parent

Letter - Explain

_____

Form - Explain

_____

This information may be exchanged and/or disclosed for the purpose of: *

_____

This authorization will expire on ____/____/____ (if left blank, this document will expire one year from the date it was signed)

_____ _____ _____

Month Day Year

Signature of patient or legal guardian (patient must sign when drug or alcohol abuse is involved even if under 18):

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this I must do so in writing and present this to my provider. I understand that revocation will not apply to information that has already been released. I understand that the revocation will not apply to my insurance carrier when the law provides my carrier the right to contest a claim under my policy. I understand that this disclosure is voluntary. I understand I may inspect or copy the information disclosed. If I have any questions I can contact The Growth Center.

- ◯ YES
- ◯ NO

Signature

_____

Date

Month Day Year