Indy Behavioral Health, LLC
2629 Waterfront Parkway East Drive, Suite 108
Indianapolis, IN 46214
317.978.0257
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Authorization for Use or Disclosure of Protected Health Information

Client Information

Client Last Name _____ First Name _____ MI _____
DOB: _____/_____/_____
Client Address
_____

Client Home Phone: _____Cell/Work Phone: _____

Client Email Address: _____

Recipient Information

I, _____, do hereby authorize _____ to release a copy of my mental health information to the person or facility below.

Name of person/facility to receive medical information: _____
Phone: _____
Address: _____

Date of Authorization: _____/_____/_____
Authorization to expire on _____/_____/_____ or upon the happening of the following event: _____
_____
_____

Information to be Released *(Note: Requests for release of psychotherapy notes cannot be combined with any other type of request.)*

□ Yes □ No I authorize the release of my entire record, including those regarding drug, alcohol, or mental health treatment to the person(s) listed above.

□ Only those portions pertaining to: _____
(Specific provider name and/or dates of treatment)

□ Authorization for Psychotherapy Notes ONLY (Important: If this authorization is for Psychotherapy Notes, you must not use it as an authorization for any other type of protected health information.)

□ Other: _____
_____

Purpose of Information Release:

□ Further mental health care □ Payment of insurance claim □ Legal investigation
□ Applying for insurance □ Vocational rehab, evaluation □ Disability determination
□ At the request of the individual □ Other (specify):

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Authorization and Signature

I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

_____ _____

Signature Date

If signed by a personal representative:

(a) Print your name:_____

(b) Indicate your relationship to the client and/or reason and legal authority for signing:

Patient is: □ minor □ incompetent □ disabled □ deceased

Legal authority: □ parent □ legal guardian □ representative of deceased