GRANT-BLACKFORD MENTAL HEALTH, INC.

505 Wabash Avenue * Marion, Indiana 46952 * phone (765) 662-3971 fax (765) 668-6718

A UNITED WAY AGENCY

AUTHORIZATION FOR RELEASE OF INFORMATION

Client Full Name : ____ Phone Number: ____________________

DOB _______________________ SSN: _________________________________

Address: ____

City: __________________________________ State: ________________ ZIP:_____________________

I Hereby Authorize: Grant Blackford Mental Health, INC to (check one)

[ ] RELEASE Mental Health and/or Substance Use/Abuse or Addiction INFORMATION TO

[ ] REQUEST Mental Health and/or Substance Use/Abuse of Addiction INFORMATION FROM

by: MAIL RECORDS [ ] FAX RECORDS [ ] BY PHONE [ ] PICK UP [ ]

Agency/Person : ____ Phone: __________________

Address: ____

City: __________________________________ State: ________________ ZIP:_____________________

Purpose of Disclosure: [ ] Continuity of Care [ ] Other (please specify) _______________________

The information to be release verbally and/or in writing is indicated by the **INITIALED** areas below, in order to protect your confidentiality – please do not “X”

_______ Assessment(s)

_______ Psychological Testing

_______ Psychiatric Evaluation

_______ Progress Notes/Case Notes

_______ Discharge Summary/Termination

_______ Treatment Plan(s)

_______ Med Clinic Notes

_______ Other: __________________________________

[ ] I authorize the release of communicable disease information, which may include HIV/AIDS information.
(requires Client’s signature) ____.

Specify the treatment period of the information to be released: __________________________________

I hold harmless Grant Blackford Mental Health, INC. in regard to use of information authorized for release or exchange. I understand that this form is not required as a condition for treatment and that it may be revoked by me in writing at any time, except to the extent that action has already been taken.

This consent will expire at the end of 180 days. The expiration date is:________________________

____ ________________________

Signature of client (parent, guardian, or legal representative) Date Signed

If signature other than client, indicate relationship to client: _________________________________

____

Signature of Witness

Note: The information received or forwarded to a receiving agency understands that the information shared is confidential according to State Law 16.39.1-8 and/or Federal Law 42 CFR Part 2.

Accredited by: The Joint Commission

Revised Oct 2012, dp