ADULT & CHILD HEALTH

For Release of Information requests:
please return form to the
Health Information Department
8320 Madison Ave., Indianapolis, IN 46227
Fax: 317-888-8642

Authorization for Release of Protected Health Information

Client/Patient Information: (Please Print)

Name: Date of Birth: Phone #:

Street Address: City: State: Zip Code:

I authorize Adult & Child Health to: (Please Check All That Apply)

❑ **Release** Information To: ❑ **Obtain** Information From: ❑ **Verbally Exchange** Information With:

Name & Relationship of Individual or Organization: Phone Number: Fax Number:

Street Address: City: State: Zip Code:

I authorize the following information to be released: (Please Check All That Apply)

❑ Assessments ❑ Physician Notes ❑ Discharge Summary ❑ Medication List
❑ Treatment Plan ❑ Psychological Evaluation ❑ Psychiatric Evaluation ❑ Current Diagnosis
❑ Reports (i.e.: School, Court, DCS, Probation) ❑ Imaging Reports (X-rays) ❑Laboratory Reports
❑Ongoing Informal Communication ❑ Other (Please Specify): _____

Date(s) of service: From ____/____/____ To ____/____/____

Release for Special Protected Information:

This authorization is valid for disclosure of alcohol and/or substance use, communicable disease, and HIV/AIDS information. If you do not want Adult & Child Health to share certain information, please check and initial below:

a. The diagnosis or treatment of alcohol and/or substance use ❑ No _____
b. The diagnosis or treatment of AIDS, including the results of HIV tests, or communicable disease ❑ No _____

Purpose for Disclosure: (Please Check All That Apply)

❑ Continuity of Care ❑ To Obtain Payment for Services ❑ Facilitate Treatment Planning
❑ Condition of Court Order ❑ Disability Determination ❑ At the Request of the Client
❑ Other: _____

Release Method/Format requested: (check one) ❑ Paper ❑ CD ❑ Patient Portal (Primary Care only) ❑ Fax ❑ Verbal

Expiration Date: This authorization will expire in 180 days unless otherwise indicated below:

❑ This authorization will expire upon the following date or condition:_____
❑ This authorization will expire 60 days past termination of services at Adult & Child Health

Right to Revoke: I understand that I have the right to revoke this authorization at any time. In order to revoke this authorization, I must do so in writing. I understand the revocation will not apply to information previously released in response to this authorization. Please fill out the section below to revoke this authorization:

❑ I am revoking this authorization. Date: Signature:

Redisclosure Notice: If I have authorized the disclosure of my health information to someone who is not legally required to keep it confidential, I understand that it may be redisclosed and no longer protected by Adult & Child Health.
Adult & Child Health will not condition the provision of treatment on execution of an authorization form, except where the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.

Client/Legal Guardian Signature:_____ **Date:**_____
(Minors receiving substance abuse services must sign the authorization form along with parent/guardian)

If signed by Guardian/Legal Representative, Provide the Relationship to Client:

Revised 8/29/2017 *A copy of this authorization shall be as valid as the original.*

❑ **File** ❑ **Release** ❑ **Obtain** **Record #:**