CONSENT FOR THE RELEASE OF CONFIDENTIAL MENTAL HEALTH RECORDS

I,_____, authorize
(The name of the patient)

_____
(The name of the person requested to release the patient's mental health record.)

to disclose to _____
(The name of the person, provider, or organization to whom the patient's mental health record is to be released)

by [ ] telephone [ ] written material [ ] Fax

for the purpose of_____.
(The purpose of the release)

The following information (A description of the information to be released from the mental health record.):

[ ] Mental health and medical history, including diagnosis
[ ] Summary of outpatient treatment
[ ] Records of hospitalization and inpatient treatment
[ ] All diagnostic, psychological assessment
[ ] Other:_____

I UNDERSTAND THAT MY RECORDS ARE PROTECTED UNDER FEDERAL AND INDIANA STATE (IC 16-39-2) CONFIDENTIALITY REGULATIONS AND CANNOT BE DISCLOSED WITHOUT MY WRITTEN CONSENT UNLESS OTHERWISE PROVIDED FOR IN THE REGULATIONS.

I ALSO UNDERSTAND THAT I MAY REVOKE THIS CONSENT AT ANY TIME BY GIVING WRITTEN NOTICE TO THE GUARDIAN OF RECORDS. IN ANY EVENT THIS CONSENT EXPIRES AUTOMATICALLY 180 DAYS FROM THE DATE OF TERMINATION OF TREATMENT.

A PHOTOCOPY OF THIS AUTHORIZATION WILL BE AS VALID AS THE ORIGINAL.

_____ _____ _____
(Signature of Patient) (Date Signed) (Patient Date of Birth)

_____
(Signature of Witness)