CHILDREN'S RESOURCE GROUP
Authorization for Disclosure of Protected Health Information (PHI)

Please return the requested information to:

Children's Resource Group
9106 N. Meridian St., Suite 100
Indianapolis, IN 46260
Phone: (317) 575-9111
Fax: (317) 571-4470

Name of Client	**Person/Organization**
Street Address	Relationship of Person/Organization
City/State/Zipcode	Street Address
DOB	City/State/Zipcode
	Phone Number

I, the undersigned, hereby authorize Children's Resource Group to release to and/or exchange with the person/organization designated above the following information concerning me, or the person I represent:

****Mark an "X" on all applicable sections before signing.**

____ Psychological Evaluation	____ Psychiatric Evaluation	____ All Progress Notes/Appointment Records
____ Medication History	____ Lab Results	____ Substance Abuse Evaluation
____ Drug/Alcohol Records	____ Billing & Financials	____ Other _____

****The specific purpose of the disclosure is (please mark one):**

¯ Coordination of Care ¯ Transfer of Care ¯ Other _____

****This is a request to <u>send</u> and/or <u>obtain</u> records and requires immediate attention. _____ (Please check if applicable)**
Please allow fourteen (14) business days to process your request. Copying fees will be charged in accordance with 760 IAC 1-71-3.

I hereby knowingly and voluntarily waive the Indiana law provision that this consent expires in one hundred eighty (180) days. This consent, unless expressly revoked earlier in writing, expires one year from date below.
Initial: Yes _____

I, the undersigned, have read or been informed of the following:

(1) I understand that my signature on this Authorization is voluntary and my refusal to sign will not affect my ability to receive treatment from the Practice.
(2) I understand that I have a right to revoke this Authorization at any time but any such revocation will not apply (1) to PHI that has already been released in reliance on this Authorization, or (2) to PHI created by the Practice expressly for disclosure to the above-listed Person/Entity.
(3) I understand that this authorization will expire in one hundred eighty (180) days from the date the authorization is executed, unless waived by me above and/or revoked by me prior to that date.
(4) I understand that the PHI disclosed may be subject to re-disclosure by the Person/Entity receiving it and no longer protected by the federal privacy regulations except in the case of drug and alcohol treatment records which must be clearly stamped "Do Not Re-Disclose" and protected accordingly under 42 CFR Part 2.
(5) I understand that if I have any questions regarding the use or disclosure of my PHI, I can contact Children's Resource Group at any time.

<u>Printed Name</u> of Patient	**<u>Signature</u> of Patient** *(A minor must always sign to release drug and alcohol treatment records, even to his or her parent or guardian.)*
<u>Printed Name</u> of Legal Representative	**<u>Signature</u> of Legal Representative**

If Legal Representative, Please Indicate Relationship to Patient: _____

Witness	**Date**