

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

 Street Address

 City/State/Zip Code

 DOB

 Phone/Fax Number

 Email

Person/Organization

 Relationship of Person/Organization

 Street Address

 City/State/Zip Code

 Phone/Fax Number

 Email

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 for records to be (please mark one):

- SENT** **OBTAINED** **or for MUTUAL DISCLOSURE as needed**

Please allow thirty (30) 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.

Printed Name of Patient

Signature of Patient *(A minor must always sign to release drug and alcohol treatment records, even to his or her parent or guardian.)*

Printed Name of Legal Representative

Signature of Legal Representative

If Legal Representative, Please Indicate Relationship to Patient: _____

Witness

Date