6296 Rucker Road, Suite A
Indianapolis, IN 46220
phone: 317-550-3043
fax: 855-845-3260

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: __________________________ DOB: ______________ Phone:_________________

Address: ______________________________ City:_____________ State:____ Zip: ____________

- I hereby voluntarily authorize and consent to disclosure of health records and/or information as stated below.
- I understand that I may refuse to sign this authorization, and that my refusal will not affect my ability to obtain services, treatment or payment for services; unless services provided are solely to create health records for a third party, such as physical and drug testing for an employer or insurance company; or if treatment provided is research related and authorization is required for the use of health information for research purposes.
- I understand that I may see and copy the information described in this form if I ask for it.
- Unless limited below, I understand that this release also pertains to records whose confidentiality is protected by either Federal Regulations (42 CFR Part 2) or State Law (IC 16-39-2) concerning hospitalization or treatment, including but not limited to, information regarding **treatment and related services for alcohol and/or substance abuse, communicable disease documentation, human immunodeficiency virus (HIV) or for mental health treatment or counseling.**

I authorize ____ to release and share information with

____

The purpose or need for the disclosure: __ at the request of the individual __ other (specify):

____

Information to be disclosed: ____

Expiration Date or Event: ____

Information to be released: __Verbally __Photocopy __Fax __Other ________________

I understand that this authorization is voluntary and that I have the right to revoke it at any time prior to its expiration date by written notification to Neurobehavioral Consultants. This revocation will not have any effect on the information released pursuant to this Authorization before the revocation. I understand that the information released may be subject to re-disclosure by any recipient and no longer protected by federal privacy laws.

_________________________	__________	_____________________________	__________
Patient Signature	Date	Parent/Guardian/Representative	Date
_________________________	__________	_____________________________	
Witness	Date	Legal Authority of Representative	