Community Mental Health Center, Inc.
285 Bielby Road
Lawrenceburg, Indiana 47025
812-537-1302 Fax 812-537-5219

Release of Protected Health Information

Client Name: _____ **Date of Birth:**_____

Client Address: _____ City/State/Zip:_____

Phone: _____ **May we leave a message about release?** ☐ Yes ☐ No

I, the undersigned, authorize **Community Mental Health Center, Inc, 285 Bielby Road, Lawrenceburg, IN 47025** to:
☐ disclose ☐ receive ☐ exchange, confidential information from the agency and/or individual listed below:

_____
Name of Person/Agency Street Address

_____
City, State, Zip Code Phone Number Fax Number

Release from the Time Period: ☐ Any Admissions ☐ Only Specified Years: _____

Information to be Released:

☐ All Areas of Record ☐ Treatment Summary ☐ Psychological Evaluation ☐ History & Physical
☐ Intake/Assessment ☐ Lab, EKG, X-Ray ☐ Psychiatric Evaluations ☐ Inpatient Discharge Summ.
☐ Treatment Plans ☐ Other, specify:

Purpose of Release: ☐ Continuity of Care ☐ Legal Proceedings ☐ Case Coordination ☐ Other: _____

I fully understand that my medical record contains confidential physical, mental health, substance abuse and/or HIV/AIDS information compiled in the course of my treatment. The medical records and/or information authorized to be disclosed hereunder are privileged and confidential and may be disclosed only on my authorization, as required by law. I understand that records not protected by Federal confidentiality rules (42CFR Part 2) may be subject to redisclosure by the recipient and may no longer be protected by Federal or State law. I understand that I cannot be required to sign this authorization as a condition for having treatment provided or obtaining payment for the same.

Date, event or condition this authorization expires: _____. **If no date, event or condition is specified, this authorization expires 60 days after services have been terminated.** I may revoke this authorization at any time (except to the extent that action has already been taken in good faith reliance on this authorization) by submitting a written or oral revocation request to the Health Information Department.

This information may be disclosed from records protected by Federal confidentiality rules (42 CFR Part 2). The federal rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Patient Signature or Parent/Guardian: _____ Date: _____

Printed Name of Parent/Guardian:_____ Relationship to Patient: _____

Witness: _____ Date: _____

Was client was given a copy of this release?	☐ Yes	☐ No
Do records need to be requested from agency at time of signing?	☐ Yes	☐ No
Do records need to be released to above agency at time of signing?	☐ Yes	☐ No

Client Name: &cltfst& &cltlst&
Client Case: &cltcas&