



RELEASE OF INFORMATION - PROFESSIONAL
AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME: _____ D.O.B. _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

I hereby request INDIANA HEALTH GROUP, INC. to: [] RELEASE to & OBTAIN from [] RELEASE to [] OBTAIN from

**** PLEASE NOTE: If contact information is not complete the release will not be valid and we will be unable to send records. ****

Person/Organization: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ E-Mail: _____

Information Requested: [] Entire Patient Record [] School Records [] Discharge/Termination
[] Alcohol/Drug Evaluation [] Diagnosis & Evaluation [] Psychological Testing
[] Other: _____

Purpose of Release: [] Treatment [] Other: _____

I understand that this request will be valid for one hundred eighty (180) days from the date written below. At that time the request will be void and no further information will be furnished pursuant to it.

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to Indiana Health Group. I understand that a revocation is not effective to the extent that Indiana Health Group has relied on the use or disclosure of the protected health information.

This release prohibits redisclosure except in accordance with 42 C.F.R., 21 et seq., which is a federal regulation governing release and use of patient record information pertaining to treatment for alcohol and drug abuse.

Indiana Health Group will not condition my treatment whether I provide authorization for the requested use or disclosure.

I agree to pay INDIANA HEALTH GROUP, INC. an actual cost incurred in preparing and delivering the information requested herein.

A copy of this authorization shall be as valid as the original.

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights).
Refuse to sign this authorization.
Receive a signed copy of this authorization.

Signature of Patient or Personal Representative

Relationship to Patient

Date

WITNESS: _____

***** INDIANA HEALTH GROUP USE ONLY *****

[] MAILED [] FAXED [] SCANNED - NO ACTION REQUIRED

[] RELEASE OF INFORMATION [] RECORDS [] OTHER: _____

IHG STAFF SIGNATURE: _____ DATE: _____