Children's Resource Group
Authorization for Disclosure of Protected Health Information (PHI)

This is a request for records to be: ☐ SENT ☐ OBTAINED ☐ MUTUAL DISCLOSURE

Please allow thirty (30) business days to process your request for records to be sent or obtained. Copying fees will be charged in accordance with 760 IAC 1-71-3

PATIENT/CLIENT INFORMATION

Name: _____ DOB: _____

Street Address: _____ City/State/Zip: _____

Phone/Fax: _____ Email: _____

RECORDS/INFORMATION TO BE RELEASED TO/OBTAINED FROM:

Person/Organization: _____ Relationship: _____

Street Address: _____ City/State/Zip: _____

Phone: _____ Fax: _____ Email: _____

I, the undersigned, hereby authorize Children's Resource Group (CRG) to release and/or exchange with the person/organization designated above the following information concerning me, or the person I represent ***(check all that apply)***:

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

PURPOSE OF RELEASE: ☐ Coordination of Care ☐ Transfer of Care ☐ Other:_____

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 the date below.
Initial: _____

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.**
(6) **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**

_____ _____
Printed Name of Patient **Signature of Patient** (A minor must always sign to release drug and alcohol treatment records, even to a parent or guradian)

_____ _____
Printed Name of Legal Representative **Signature of Legal Representative**

If Legal Representative, Please Indicate Relationship to Patient: _____

_____ _____
Witness **Date**

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