

The
Growth Center
4925 Charlestown Rd. New Albany, IN 47150
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

PATIENT NAME: _____

DATE OF BIRTH: ____/____/____

- I authorize the use or disclosure of the above named individual's health information as described below.
- The following individuals or organizations are authorized to *exchange* information:

(I)	(II) RELEASE INFO TO/FROM:
Name: The Growth Center	Name: _____
	Business Name: _____
Address: 4925 Charlestown Rd. New Albany, IN 47150	Address: _____
	City: _____ State / Zip: _____
Phone: (812) 941-9200	Phone 1: _____
	Phone 2: _____
Fax: (812) 941-9205	Fax: _____

***** The patient or guardian must **(INITIAL)** each applicable item below *****

1) **PURPOSE** for health info disclosure (initial & check those that apply):

- | | |
|---|---|
| <input type="checkbox"/> Continuity of Care () | <input type="checkbox"/> Disability Renewal/Application () |
| <input type="checkbox"/> Return to Work () | <input type="checkbox"/> Treatment/Billing Coordination () |
| <input type="checkbox"/> Legal Proceedings () | <input type="checkbox"/> Other: _____ () |
| <input type="checkbox"/> School Assessment () | |

2) **SPECIFIC INFORMATION** requested to be disclosed (initial & check those that apply):

- | | |
|---|---|
| <input type="checkbox"/> Entire Admission History / Med Records including: patient histories, office notes (except psychotherapy notes and records received from other health care providers), personal information, billing and insurance records. () | <input type="checkbox"/> Medical Records (From: _____ To: _____) () |
| | <input type="checkbox"/> Billing, Insurance, Tx Dates, Demographic Info () |
| | <input type="checkbox"/> Psychiatric Evaluation Only () |
| | <input type="checkbox"/> Other, explain: _____ () |
| | <input type="checkbox"/> Treatment Summary () |

3) **HOW** would you like the information disclosed (initial & check those that apply):

- Med Records to be SENT / RECVD (Circle One) FROM: _____ (Listed as II above) ()
- Speak w/ Person: _____ (Name/Relationship) ()
- Letter, explain: _____ ()
- Form, explain: _____ ()
- Other: _____ ()

4) This information may be exchanged and/or disclosed for the purpose of _____

5) I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this I must do so in writing and present this to my provider. I understand that revocation will not apply to information that has already been released. I understand that the revocation will not apply to my insurance carrier when the law provides my carrier the right to contest a claim under my policy. I understand that this disclosure is voluntary. I understand I may inspect or copy the information disclosed. If I have any questions I can contact The Growth Center () (initial).

6) This authorization will expire on ____/____/____ (if left blank, this document will expire one year from the date it was signed).

7) Signature of patient or legal guardian (patient must sign when drug or alcohol abuse is involved even if under 18):

Patient / Guardian Signature: _____	(PRINT): _____	Date: _____
Witness Signature: _____	(PRINT): _____	Date: _____