The
Growth **C**enter
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 discloser (initial & check those that apply):

- ☐ Continuity of Care (_____)
- ☐ Return to Work (_____)
- ☐ Legal Proceedings (_____)
- ☐ School Assessment (_____)
- ☐ Disability Renewal/Application (_____)
- ☐ Treatment/Billing Coordination (_____)
- ☐ Other: _____ (_____)

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

- ☐ 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. (_____)
- ☐ Medical Records (From: _____ To: _____) (_____)
- ☐ Billing, Insurance, Tx Dates, Demographic Info (_____)
- ☐ Psychiatric Evaluation Only (_____)
- ☐ Other, explain: _____ (_____)
- ☐ Treatment Summary (_____)

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

- ☐ Med Records to be **SENT** / **RECV'D** (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: _____	