AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI) TO DR. THOMAS A. BATTOCLETTI (SUPERVISING HEALTH SERVICE PROVIDER IN PSYCHOLOGY)

Patient Name: _____ Date of Birth: _____ Age: _____

Address: _____ City/State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

I hereby authorize and request that Innovative Interventions, LLC:

☒Release/Disclose Information to: ☒Obtain Information from:

Name/Agency: Thomas A. Battocletti, Ph.D., HSPP, Clinical Psychologist (Supervisor)

Address: 9670 E. Washington St., Ste. 200, Indianapolis, IN 46229 Phone: (317) 890-5722

Purposes for the Release/Disclosure of Protected Health Information:

☒For Dr. Battocletti to supervise the therapist(s) providing treatment through Innovative Interventions, LLC.

☒For Dr. Battocletti to securely maintain photocopies of any/all Clinical Records, Psychotherapy Notes, and Billing Records pertaining to services that have been rendered under his supervision.

The Protected Health Information to be Released/Disclosed:

☒Intake Assessment	☒Attendance to Sessions	☒Treatment Plan
☒Diagnosis	☒Psychological Report/Testing	☒Treatment Summary
☒Psychotherapy Notes	☒School Behavior Records	☒Discharge Summary
☒Mentor Notes	☒Medications/Medical History	☒Billing Records

☐ Other: _____

Protected Health Information to be Released/Disclosed: ☒Verbally ☒U.S. Postal Service ☒Fax ☒Photocopy ☒In-Person ☒Phone ☒Telehealth Platform ☐ Other: _____

I understand that these records may contain information relating to behavioral or mental health (psychological) services, HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse. I give my specific authorization for these records to be released/disclosed.

I understand that I have the right to revoke this authorization at any time by providing written notification to Innovative Interventions, LLC, at Methodist Medical Plaza East, 9670 E. Washington Street, Suite 200, Indianapolis, IN 46229.

I understand that any such revocation will not be effective to the extent that Innovative Interventions, LLC, has already taken action in response to this authorization or if otherwise required by legal contract or court order.

I understand that any information released/disclosed as per this specific authorization may be re-disclosed by the person or entity receiving the information. In such a situation, it will no longer be protected by this authorization.

I understand that this authorization will expire on _____. If I fail to specify an expiration date, event or condition, this authorization will expire in one year from the date it was signed.

I understand that a copy or facsimile (fax) of this authorization is as valid as the original.

I understand that I have the right to receive a copy of this authorization. Copy of the authorization received. ☐ _____ (Initials)

I hereby release Innovative Interventions, LLC, from any and all liability and injuries that may arise from the disclosure of this information to the party named above. I have read the above or had it read to me and I authorize the release/disclosure of the Protected Health Information stated.

_____ _____

Patient Signature Date

Parent/Guardian/ Representative Signature Date

_____

Legal Authority of Representative

_____

Witness Date