AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name: ________________________________ Date of Birth: _______________ Age: _________

Address: __________________________________ City/State: __________________ Zip Code: ________

Home Phone: _______________ Work Phone: ________________ Social Security Number: ______________

I hereby authorize and request that Innovative Interventions, LLC:

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

Name/Agency: ____

Address: ____ City/State: _________________________

Zip Code: ___________ Phone #: ________________________ Fax #: ______________________________

Purposes for the Release/Disclosure of Protected Health Information:

☐ At the request of the patient (or legal guardian) ☐ Other: ____

The Protected Health Information to be Released/Disclosed:

☐ Billing Records ☐ Attendance to Sessions ☐ Treatment Plan

☐ Initial Evaluation ☐ Psychological Report/Testing ☐ Treatment Summary

☐ Diagnoses ☐ School Behavior Records ☐ Discharge Summary

☐ Psychotherapy Notes ☐ Medications/Medical History

☐ Other: ____

Protected Health Information to be Released/Disclosed: ☐ Verbally ☐ U.S. Postal Service ☐ Fax

☐ Photocopy ☐ 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 I am not required to sign this authorization and that my treatment will not be affected if I refuse to sign 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