



CONSENT FOR RELEASE INFORMATION

I, the undersigned, hereby authorize the disclosure of any mental health, general health, education, or alcohol & drug use information regarding me specifically with and between the following two (2) parties as described below:

[1]

_____ (Therapist)

Groff & Associates, LLC
7425 East 86th Street (Physical);
Indianapolis, IN 46256-1207 (46250-7246 Mailing)

PHONE: (317): _____ - _____
FAX: (317) 578-0828

EMAIL: _____@GroffandAssociates.com

AND

COMPANY NAME	CONTACT NAME		
TITLE	PHONE	EMAIL	
STREET ADDRESS	CITY	STATE	ZIP

[2] Specific description of the information to be used or disclosed:

- | | | |
|--|--|---|
| <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Medication | <input type="checkbox"/> Recommendations |
| <input type="checkbox"/> Progress and Treatment | <input type="checkbox"/> Lab Results/Drug Screen | <input type="checkbox"/> Psychiatric Eval. |
| <input type="checkbox"/> Social History | <input type="checkbox"/> Educational Assessment | <input type="checkbox"/> Reason for Treatment |
| <input type="checkbox"/> Psychological Testing Results | <input type="checkbox"/> # of Kept/Unkept Appts. | <input type="checkbox"/> Other: _____ |

[3] The information may be used or disclosed for each of the following purposes:

- | | | |
|---|--|---|
| <input type="checkbox"/> Court Order | <input type="checkbox"/> Collaboration with School | <input type="checkbox"/> Client Treatment |
| <input type="checkbox"/> Court Testimony | <input type="checkbox"/> Collaboration for Program | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Confirmation of Referral | <input type="checkbox"/> At the Request of Client | |

