AUTHORIZATION TO RELEASE INFORMATION

I, _____ hereby authorize the disclosure of any physical
CLIENT/PARENT/GUARDIAN

health, mental health, general health, education, or alcohol/drug use information for myself or

_____ specifically with and between the following two
CLIENT NAME

(2) parties as described below:

[1]

_____
CLINICIAN'S NAME

Groff & Associates, LLC
7425 East 86th Street
Indianapolis, IN 46256-1207

MAIL: P.O. Box 502246
Indianapolis, IN 46250-7246
PHONE: (317) 474-6448 ext. ___
FAX: (317) 468-9905

EMAIL: _____@GroffandAssociates.com

AND

COMPANY NAME	**CONTACT NAME**	**TITLE**
PHONE #	**EMAIL**	**FAX #**
STREET ADDRESS	**CITY**	**STATE** **ZIP**

❑ **Please check this box if you wish to authorize the disclosure of *all* information described in the sections below.**

OR

Check the specific information you wish to be disclosed:

[2] Description of the information to be disclosed:

- ❑ Diagnosis
- ❑ Progress and Treatment
- ❑ Social History
- ❑ Psychological Testing Results
- ❑ Medication
- ❑ Lab Results/Drug Screen
- ❑ Educational Assessment
- ❑ # of Kept/Unkept Appts.
- ❑ Recommendations
- ❑ Psychiatric Evaluation
- ❑ Reason for Treatment
- ❑ Financial Needs
- ❑ Other:_____

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

- ❑ Court Order
- ❑ Court Testimony
- ❑ Confirmation of Referral
- ❑ Collaboration with School
- ❑ Collaboration for Program
- ❑ At the Request of Client
- ❑ Client Treatment
- ❑ Other: _____

[4] The designated information may be transmitted by mail, fax, electronic mail, or the designated parties may discuss by telephone the content of the information to be released. I understand that the information used or disclosed may be subject to re-disclosure by the person(s) or class of person(s) receiving it and no longer protected by the federal privacy regulations.

[5] I understand that I may revoke this authorization by notifying Groff & Associates in writing, at the address above, of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any effect on actions already taken by Groff & Associates in reliance on this authorization.

[6] I understand that this information may include information relating to:

- Acquired Immunodeficiency Syndrome (AIDS)
- Human Immunodeficiency Virus (HIV)
- Treatment for drug or alcohol use.
- Mental and behavioral health or psychiatric care.

[7] I understand that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, nor my eligibility for benefits. Groff &Associates, may refuse to provide treatment only in circumstances where Groff & Associates provided care to you solely for the purpose of creating protected health information for disclosure to a third party.

[8] I understand that this authorization will expire in one year.

[9] I understand that there may be administrative charges associated with the use or disclosure of this information should any information need to be disclosed in writing.

This form must be fully completed before signing.

_____ _____

SIGNATURE OF CLIENT/RESPONSIBLE PERSON **DATE**

_____

PRINTED NAME OF CLIENT/RESPONSIBLE PERSON

