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2002 S. East Street • Indianapolis, IN 46225 T. 317.803.9715

F. 317.454.8573

## **AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

## Psychiatric, Alcohol, Substance Use Records, HIV Related Information

I (the undersigned) hereby authorize, GRM to disclose the following identified health information.

Maiden Name (if applicable): SSN:  Date of Birth: E-mail Address:	PATIENT INFORMATION				
Date of Birth:	Name of Patient:			Date:	
Address:				SSN:	
City, State, Zip Code:  RELEASE INFORMATION FROM  Care Provider Name:	Date of Birth:			E-mail Address:	
Care Provider Name:	Address:			Phone Num	nber:
Information to Be Released   Dates of Treatment Requested:   I give special authorization to release Information regarding:   Psychiatric/Mental Health   Alcohol   Substance Use Records   HIV Information   Information to release. Check all that apply:   All Records   Office Visit Notes   Discharge Summany (s)   Itemized Billing on CD   Prescriptions   Test & X-ray Reports   Other   Oth	City, State, Zip Code:				
Dates of Treatment Requested:    give special authorization to release information regarding:   psychiatric/Mental Health	RELEASE INFORMATION FROM				
Dates of Treatment Requested:	Care Provider Name:		Address:		
Information to release. Check all that apply:    All Records	INFORMATION TO BE RELEASED				
Information to release. Check all that apply:    All Records	Dates of Treatment Requested:				
Information to release. Check all that apply:    All Records	I give special authorization	to release in	formation regarding:		
All Records	☐ Psychiatric/Mental Health	Alcohol	☐ Substance Use Re	ecords	☐ HIV Information
RELEASE INFORMATION TO (if not patient)  Name:	<ul> <li>☐ All Records</li> <li>☐ Office Visit Notes</li> <li>☐ Prescriptions</li> <li>☐ History &amp; Physical</li> </ul>		Discharge Summary (s) Test & X-ray Reports Operative Report (s)		Itemized Billing on CD
Address: E-mail Address: Phone Number: Purpose for disclosure: Phone Number: Purpose for disclosure: Phone Number: Purpose for disclosure: I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to GRM, attention: ROI Department, 2002 S. East Street, Suite 1, Indianapolis, IN 46225. I understand that this authorization will expire in sixty, (60) days unless otherwise specified. **Expiration Date (if not sixty days)  I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand I am responsible for all copy fees under Federal and State Law. I understand that I have the right to refuse to sign this authorization. By signing this authorization, I acknowledge that I have read and understand this authorization. Further, I authorize the use or disclosure of my Protected Health Information in accordance with the terms of this authorization.  Signature of Patient: Date:	Limitations: Do not release information	in my records rega	arding:		
Address:	RELEASE INFORMATION TO (if no	t patient)			
Address:	Name:				
City, State, Zip Code:					ess:
Purpose for disclosure:  I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to GRM, attention:  ROI Department, 2002 S. East Street, Suite 1, Indianapolis, IN 46225. I understand that this authorization will expire in sixty, (60) days unless otherwise specified.  *Expiration Date (If not sixty days)  I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand I am responsible for all copy fees under Federal and State Law. I understand that I have the right to refuse to sign this authorization. By signing this authorization, I acknowledge that I have read and understand this authorization. Further, I authorize the use or disclosure of my Protected Health Information in accordance with the terms of this authorization.  Signature of Patient:					
ROI Department, 2002 S. East Street, Suite 1, Indianapolis, IN 46225. I understand that this authorization will expire in sixty, (60) days unless otherwise specified.  *Expiration Date (if not sixty days)  I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand I am responsible for all copy fees under Federal and State Law. I understand that I have the right to refuse to sign this authorization. By signing this authorization, I acknowledge that I have read and understand this authorization. Further, I authorize the use or disclosure of my Protected Health Information in accordance with the terms of this authorization.  Signature of Patient:					
Relationship to patient, if other than patient:	I understand that I have the right to revo ROI Department, 2002 S. East Street, Sunless otherwise specified. *Expir I understand that information used or di no longer be protected by federal or si I understand that I have the right to rei that I have read and understand this au	oke this authorizat Suite 1, Indianapo ation Date (if not sclosed pursuant tate law. I underst fuse to sign this a uthorization. Furthe	ion, in writing, at any time by s lis, IN 46225. I understand the sixty days) to this authorization may be s and I am responsible for all outhorization. By signing this	at this authorization——·  ubject to re-disclo opy fees under Fe authorization. I ac	on will expire in sixty, (60) days sure by the recipient and may ederal and State Law. knowledge
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