Secure. Reliable. Easy.

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.

PATIENT INFORMATION

Name of Patient:______________________________ Date: ______________

Maiden Name (if applicable):______________________________ SSN: ______________

Date of Birth:______________________________ E-mail Address: ______________

Address:______________________________ Phone Number: ______________

City, State, Zip Code: ______________________________

RELEASE INFORMATION FROM

Care Provider Name: ______________________ Address: ______________________

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
- ☐ Prescriptions
- ☐ History & Physical
- ☐ Labs
- ☐ Consultation Report (s)
- ☐ Discharge Summary (s)
- ☐ Test & X-ray Reports
- ☐ Operative Report (s)
- ☐ Therapy Note (s)
- ☐ MRI / X-ray Images
- ☐ Itemized Billing on CD
- ☐ Other ______________

Limitations: Do not release information in my records regarding: ______________________________

RELEASE INFORMATION TO (if not patient)

Name: ______________________________

Address:______________________________ E-mail Address: ______________

City, State, Zip Code:______________________________ 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: ______________

Relationship to patient, if other than patient: ______________________________

Witness:______________________________ Date: ______________