Continuum
Mental Health & Wellness
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HIPAA Authorization Form To Release Medical Information

I, the undersigned, hereby authorize the release of information from my medical records concerning my hospitalizations or treatments, including, but not limited to, information regarding treatment of drug or alcohol abuse, psychological conditions, communicable diseases, HIV testing or an AIDS related condition.

Patient Name: _____ **Date of Birth:** _____

Continuum: Mental Health and Wellness is to: [ ] Send records to the following: [ ] Request records from the following:
Name of Individual/Group: _____
Address: _____
Phone: _____ Fax: _____

Release records for the following dates of service: [ ] All [ ] Only for dates _____ to _____

The Following Information May Be Released *(*please check all that apply):
[ ] Discharge Summary [ ] Nursing Notes [ ] Doctor's Orders/Progress Notes
[ ] History & Physical [ ] Tests & X-rays [ ] Psychological Records[ ] Intake Notes
[ ] All records written & typed [ ] Medication Records [ ] Psychotherapy Notes [ ] Other:

Purpose of the Release*:*
[ ] Coordination of care with another provider [ ] Claims Administration/Payment [ ] Employer Mandated Treatment
[ ] Subpoena or other legal process [ ] Other: _____
[ ] At Patient's Request (*check here if you do not wish to specify a reason for the release*)

I understand I have the right to revoke this authorization, in writing, at any time by sending such written notification to Continuum: Mental Health and Wellness at 2620 Kessler Blvd. East Dr., Ste. 235 Indianapolis, IN 46220. I understand the revocation will not apply to information that has already been released in response to this authorization or to information released in reliance upon this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that my provider generally may not condition treatment services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party. I further understand that I may file a complaint against my provider for violations of the Health Insurance Portability and Accountability Act (HIPAA, **45 CFR 164**) without fear of retaliation.

I understand that I (or my legal representative) am entitled to a copy of this authorization, and that I may inspect or copy the information to be used or disclosed, as provided in **45 CFR 164.524**. I understand any disclosure of information carries with it the potential for an unauthorized redisclosure to individuals not subject to the requirements of HIPAA, and that the information may no longer be protected by HIPAA or other state or federal privacy laws.

This consent will expire (*please check one*):
[ ] One year after the signature date (/ / **20**___)
[ ] By my written revocation only
[ ] On the following date: _____

I hereby state that I have read and fully understand the above statements as they apply to me.

Signature of Patient or Legal Representative Date

Printed Name