



Improving
lives of
children
and their
families.

Meridian Youth Psychiatric Center

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Indianapolis, Indiana 46240

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AUTHORIZATION TO RELEASE INFORMATION

1. I, _____ hereby authorize
Legal Guardian, Health Care Representative or Patient if of Legal Age

Meridian Youth Psychiatric Center P.C (MVPC) to **release/obtain** the following identified information indicated below .

2. _____ / _____
Patient's Name Birth Date

Patient's Address

3. Information to be released/obtained:

I understand that authorization extends to all or any part of the records/information designated below which may include treatment for physical and mental illness, alcohol/drug abuse, HIV/AIDS test results or diagnoses. The information to be used or released includes:

- | | | |
|---|---|--|
| <input type="checkbox"/> Treatment Summary | <input type="checkbox"/> History and Physical | <input type="checkbox"/> School Testing, Grades, |
| <input type="checkbox"/> Initial Assessment | <input type="checkbox"/> Lab Results | <input type="checkbox"/> Case Conference Report , IEP |
| <input type="checkbox"/> Psych Testing | <input type="checkbox"/> Consultations | <input type="checkbox"/> School Behaviors & Performance |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Medication records | <input type="checkbox"/> All Pertinent to Assessment & Treatment |
| <input type="checkbox"/> Other _____ | | |

The authorization is limited to only that information that I have requested above to be used or disclosed to the persons/families named herein. I hereby release MVPC from all legal responsibilities or liability that may arise from the use or disclosure of medical records and other health information in reliance on this authorization.

4. Information shall be released **to/by:** _____

Name and address of person or organization

5. Purpose for the disclosure: Assessment & Treatment Communication Continuity of Care

Other: _____

6. Dates of Treatment: _____

MVPC will not condition treatment, payment or eligibility for benefits on whether this authorization is signed.

I understand that I may revoke this authorization at any time in writing. Otherwise, this consent will be considered valid for a one hundred eighty (180) day period or for the time period as specified in I.C. 16-4-8.

I further agree to pay to the Meridian Youth Psychiatric Center, P.C. the actual cost incurred in preparing the copy of the requested information.

7. _____ Date _____
Patient, Guardian, Parent or Health Care Representative

Relationship to patient, if other than patient