Meridian Youth Psychiatric Center
210 E. 91st Street, Suite C
Indianapolis, Indiana 46240

Telephone 317-844-0055
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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 (MYPC) 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 tredment for physical and mental illness, alcohol/drug abuse, HIV/AIDS test results or diagnoses. The information to be used or released includes:

__ Treatment Summary	__ History and Physical	__ School Testing, Grades,
__ Initial Assessment	__ Lab Results	__ Case Conference Report , IEP
__ Psych Testing	__ Consultations	__ School Behaviors & Performance
__ Progress Notes	__ Medication records	__ All Pertinent to Assessment & Treatment

__ Other ____

The authorization is limited to only that information that I have requested above to be used or disclosed to the persons/faclities named herein. I hereby release MYPC 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: ____

MYPC 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. ____ ________________
   Patient, Guardian, Parent or Health Care Representative / Date

   ____
   Relationship to patient, if other than patient