MERIDIAN HEALTH Services

AUTHORIZATION FOR BEHAVIORAL HEALTH RELEASE OF INFORMATION

PATIENT INFORMATION:	Name:	DOB:
	Address:	
	City: State: Zip:	Phone:
Information to be Released From: (Where do you want the information to be released from?)	Name:	
	Address:	
	City: State: Zip:	
Information to be Released To: (Who do you want to receive the information?)	Name:	
	Address:	
	City: State: Zip:	
	Fax No: Attention:	
Information to be Released: (Please note that only the minimum necessary will be released. This may result in fewer records being sent than requested.)	**Dates of Service:**	
	Physician's Office Medical Records: ☐ Immunization record ☐ Progress Notes ☐ Laboratory reports ☐ Medications ☐ Physical/Well Baby Check ☐ Consultations ☐ Other records - specify record type(s):	
	☐ Billing Records	
Special Authorization Section: (Please note that only the minimum necessary will be released. This may result in fewer records being sent than requested.)	**State and Federal Law protects the following information. If this information applies to you, please indicate if you would like this information released/obtained (include dates where appropriate):** Alcohol, Drug, or Substance Abuse Records ☐Yes ☐No ☐N/A HIV Testing and Results ☐Yes ☐No ☐N/A Communicable Disease Information ☐Yes ☐No ☐N/A Mental Health Records ☐Yes ☐No ☐N/A ☐ Treatment Plan ☐ Progress Notes ☐ Discharge Summary ☐ Group Therapy Notes ☐ Diagnoses ☐ Medications ☐ Drug Screen ☐ Psychiatric Evaluation ☐ ANSA/CANS ☐ Other records - specify record type(s):	
Release Instructions: (How and when do you want the information?)	Release Method/Format requested: (check one) ☐ Paper ☐ Fax (patient care only) ☐ Verbal	
	☐ Electronic Access/E-mail address:	
	Date information is needed: NOTE: Please allow 10 business days for processing	
Purpose of Release: (Why is it needed?)	☐ Coordination of care (records to provider) ☐ Transfer of care* ☐ Personal use or review* ☐ Other* _____ ***Fees may be charged in accordance with Indiana State Laws**	

- This authorization will expire in 180 days from the date signed unless otherwise specified. Expires: _____
- I understand that I have the right to revoke this authorization at any time. In order to revoke this authorization, I must do so in writing and present my written revocation to the above named authorized entity. The revocation will not apply to information that has already been released in response to this authorization.
- I understand that I am not required to sign this authorization in order to receive health care treatment.
- MHS records may include records that it received from other organizations. If these records have been used by MHS and filed in the record MHS maintains about you, these records may be released with your MHS records.
- MHS cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release MHS from any and all liability resulting from redisclosure by the recipient.

Your signature indicates that you have read and understand this form and you authorize release of your information as described above.

_____ _____

Patient/Legal Guardian Signature **Date**

_____ _____

Printed Name **Witness (if applicable)**

_____ _____

Authority to act on behalf of patient (attach documentation as necessary) **Witness Date/Time**