Broad Ripple Therapy Associates
6524 Carrollton Ave | Indianapolis, IN 46220

Release of Information

This form provides your written consent authorizing Broad Ripple Therapy Associates to release and obtain information pertinent to the mental health care of:

Client name			
Address			
City/State/Zip Code			
Daytime Phone		Evening Phone	
SSN			

Information can be mutually exchanged between Broad Ripple Therapy Associates and the following individuals and/or agencies:

Name		Phone	
Address			
City/State/Zip Code			

Name		Phone	
Address			
City/State/Zip Code			

Name		Phone	
Address			
City/State/Zip Code			

Information to be released:

	Diagnosis		Dates of participation		Prognosis
	Treatment Plan		Treatment Status		Other

The purpose of this authorization is	

I understand that I have the right to inspect the information to be released and that I may withdraw this authorization at any time except to the extent that action has been taken based on this authorization. I understand that this authorization shall expire, without express revocation, 60 days from the date written below. I do/ do not wish to have this information re disclosed.

Signature		Date	
Signature of Witness			

This information is disclosed from the records whose confidentiality is protected by Federal Law. Federal Regulation (42 CFR, Part 2) prohibits any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.