Proudly Serving Four (4) Locations: Comprehensive Health Care, Paoli 812.723.3944 (F) 812.723.7128
Crawford Family Health, Marengo 812.365.3221 (F) 812.365.9502
Patoka Family Health, English 812.338.2924 (F) 812.339.3706
Valley Health, West Baden 812.723.7125 (F) 812.936.2599
Providers: Teresa Faulkner, LCSW, Brandy Terrell, LCSW, Sherrie Anderson, BHC, Sheila Kempf, BHC

Authorization to Release Mental/Behavioral Health Information

Patient's Name: _____ Previous Name _____

DOB: _____ SSN: _____ Phone: _____

Address: _____

I hereby authorize release of information:

□ **To Myself:** I request SICHC, Inc. to release my protected health information to **myself** to the address listed above.
□ **From SICHC**, Inc. to the address or fax below

Hospital / Office Name: _____

Address: _____ City/State/Zip: _____

Phone: _____ Fax: _____

Record Preferences: □ Electronic □ Paper **(request >100 pgs. Will be electronic)**

Mental/Behavioral Health records that are authorized to be released:
Please check (Ö) the appropriate item(s):

□ Psychosocial Assessment □ Medications □ Psychiatric Eval/Tests
□ Psychosocial Eval/Tests □ Psychological Testing Results □ Progress Notes
□ Treatment Plan □ Group Therapy Notes
□ Other (Please Specify): _____

To authorize the release of medical records, in addition to mental/behavioral health records, a separate Authorization for Release of Medical Records must be completed.

I understand that I may revoke this release at any time in writing. This request shall remain valid until revoked or upon the expiration of sixty (60) days, whichever comes first. I also understand that this releases alcohol and/ or substance abuse information. I also understand that HIV, AIDS, and/or any sexually transmitted diseases might also be released. I understand that is will take at least 48 hours to process this request.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

□ Patient Identification Verified. _____ Date Printed/Faxed/Mailed. Signature _____

□ Patient Identification Verified Personnel Verifying Pickup: _____

This request serves as a legal and binding document