



Proudly Serving Four (7) Locations: Bedford 812.675.4470 (F) 812.675.4469
 Paoli 812.723.3944 (F) 812.723.7128
 Marengo 812.365.3221 (F) 812.365.9502
 Mitchell 812.992.5440 (F) 812.992.5441
 Orleans 812.723-3944
 English 812.338.2924 (F) 812.339.3706
 West Baden 812.723.7125 (F) 812.936.2599

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):

- Initial Assessment (past year) Treatment Plan (past year) Progress Notes (past year)
- Psychiatric Eval/Tests Psychiatric Progress Notes (past year) Psychological Testing Results
- Active Medication List
- Other (Please Specify): _____

A separate Authorization form is required to release medical records.

I understand that I may revoke this release at any time with a written request. This request shall remain valid until revoked or upon the expiration of sixty (60) days, whichever comes first. I also understand that this release of information can include alcohol and/or substance abuse, as well as HIV, AIDS, and/or any sexually transmitted diseases.

I understand that it 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