

MIDWEST ADDICTIONS PSYCHIATRIC & PSYCHOLOGICAL SERVICES
(MAPPS)

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT NAME: _____ DOB: _____

I HEREBY GIVE MY PERMISSION FOR MAPPS TO:

Please initial

Release To: _____
Obtain From: _____
Exchange With: _____ (Name of person or agency) _____ (Phone number)

INFORMATION AUTHORIZED TO BE RELEASED:

Please initial areas below

_____ Initial Assessment _____ Drug or Alcohol Treatment
_____ Psychiatric Evaluation _____ Testing Reports
_____ Psychological Evaluation _____ Information regarding HIV status or AIDS
_____ Summary of Contact _____ other: Specify: _____

Specify the treatment period of the information to be released: _____

RELEASED FOR THE PURPOSE OF: ___Progress reporting ___Coordination of treatment
___To provide information to family or caregivers ___Other (specify) _____

Expiration Date of Authorization: This authorization is effective through ___/___/___; otherwise this authorization will expire 90 days from the date of my signature.

Right to terminate or Revoke Authorization: I understand that I may revoke or terminate this authorization at any time and that the revocation or termination must be by submitting a written revocation or termination to MAPPS.

Re-disclosure: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR, Par 2, Sec. 2.31 of PL-93-282). The Federal rules prohibit you making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, P2. A general authorization of the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Signed: _____ Date: _____
(Patient)

If patient is unable to give authorization because of age, physical condition or otherwise, please complete the following: ___Minor ___Physical condition ___other: _____.

The undersigned hereby certifies and attests that he or she is the duly authorized representative of the patient and has lawful authority to enter into this authorization on behalf of the patient.

Signature of Legal Representative: _____ Date: _____

Printed Name of Legal Representative: _____ Relationship _____

Witness: _____ Date: _____