NORTHEASTERN CENTER
YOUR COMMUNITY COUNSELING CENTER

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ authorize The Northeastern Center, Inc. to release to:

Name of Client

Street Address

City State Zip Code

Birthdate

Treatment Dates

_____ *
Name and Title

_____ *
Organization

Street Address

City State Zip Code

Phone Number Fax Number

***the core documents from my current year medical/clinical record as initialed below in the following methods:**

____mail; ____verbally; ____electronically; ____fax (emergency only):

____Behavioral Health Assessment	____Medication Record	____Termination Summary	Other: (Specify):
____Treatment Plan/Reviews	____Psychiatric Evaluation(s)	____Discharge Summary	

PURPOSE OF DISCLOSURE(S):

REGARDING RELEASE OF MENTAL HEALTH SERVICES INFORMATION ONLY

I authorize a waiver of 180-day expiration period: Signature: _____ Date: _____
(This signature authorizes 180 Day Waiver Only)

I have been informed that the State of Indiana, I.C. 16-39-2-5(d), restricts consent to release mental health services information to a 180-day period following the date of my signature. However, the specific purpose of this release extends beyond the 180-day period following my signature. Therefore, I expressly waive my right to the 180-day limitation and **authorize this consent to continue until the purpose of the release is fulfilled or until _____ (date)** whichever comes first.

In all cases, the release expires upon formal termination of the clinical record following the conclusion of treatment, and in no case later than one (1) year from execution.

AGREEMENT

I hold harmless the Northeastern Center, Inc. in regard to use of information authorized for release or exchange. I understand that this form is not required as a condition for treatment and that it may be revoked by me at any time, except to the extent that action has already been taken. In the absence of revocation, this consent will expire 180 days from the date of valid signature except in the event I have signed a waiver extending the consent beyond the 180-day period. I understand information released may be subject to redisclosure from the receiving agency. I have read and understand the above and acknowledge that it was properly completed prior to my signature. A photocopy of the authorization is authentic as the original signed Authorization for Release of Information. An original will be retained in the Medical Record. I understand the parties receiving this information will be advised of its confidentiality.

SUBSTANCE ABUSE SERVICES ONLY

NOTICE TO PARTIES RECEIVING INFORMATION
PROHIBITION ON REDISCLOSURE

This information has been disclosed to you from records protected by Federal confidentiality rules, 42 CFR Part 2. The Federal rules prohibit you from 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 Part 2. A general authorization for the release of medical and 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.

DISCLOSURE TO COURT OR PROBATION

If my participation in treatment is a condition of my release from confinement, the disposition of a criminal proceeding against me, the execution of a sentence imposed upon me, or the suspension of a sentence imposed upon me, I understand that treatment information will be shared with applicable court and/or probation personnel. This consent may not be revoked by me unless (1) there has been a formal and effective termination or revocation of my release from confinement, probation, or parole; or (2) there has been a substantial change in my status. This may occur in the following circumstances: if arrested, when I am formally charged or unconditionally released from arrest; if formally charged, when charges are dismissed with prejudice, or trial has commenced; if brought to trial, which had commenced at the time of this release, when acquitted or sentenced; or, if sentenced, when the sentence has been fully executed. It is my responsibility to inform my primary therapist/case manager of any such substantial change in status.

For substance Abuse Information, client must sign, including minors:

Signed: _____ Date: _____

Signed: _____ Date: _____
(Legal Guardian or parent of minor)

Witness: _____ Date: _____

Revocation Notification: This released is revoked effective on _____ via: Verbal Request Written Request
By: (Initials): _____ Date _____ (Check One)