Premier Psychology of Indiana, LLC
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AUTHORIZATION FOR RELEASE AND EXCHANGE OF INFORMATION

I hereby consent and authorize the release and exchange of information for coordination of care between Premier Psychology of Indiana, LLC and the following individual or organization:

Name/Organization: ____

Address: ____

City: ______________________________ State: __________ Zip Code: _________

Phone Number: ____________________ Fax Number: ____________________

Type of information to be disclosed (check all that apply):
☐ Attendance in Treatment
☐ Progress in Treatment
☐ Diagnosis/Prognosis
☐ Discharge Summary
☐ Progress Notes
☐ Psychological/Psychoeducational Evaluation
☐ Other: ____

Patient Name: ____

Patient Date of Birth: ____

Address: ____

City: ______________________________ State: __________ Zip Code: _________

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws. I understand that this authorization shall be valid for one year from the date of signing or when the patient turns 18 years old, whichever comes first. I understand that I may revoke this authorization at any time by writing to Premier Psychology of Indiana, LLC at the address listed above this document, except to the extent that action has already been taken based on this authorization. I understand that Premier Psychology of Indiana, LLC reserves the right to charge for the reproduction of Medical Records in accordance with state laws. I agree that a photocopy of this authorization shall be as valid as the original.

____
Signature of Patient/Parent/Legal Guardian Date

____
Printed Name of Patient/Parent/Legal Guardian

Premier Psychology of Indiana, LLC use only:

____
Signature of Recipient Date

____
Printed Name of Recipient