



**CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

I authorize:                    Maria A. Valena, M.D.    James B. Teague, Ph.D.    Pat Grey, LMHC  
    Robert Jeffries, Ph.D.    Dena Seifert, FNP

to disclose to and/or obtain from \_\_\_\_\_

Unless limited below, I understand that this release also pertains to records whose confidentiality is protected either by Federal Regulations (42 CFR Part 2) or State Law (IC 16-39-2), including but not limited to, information regarding treatment and related services for alcohol and/or substance abuse, communicable disease documentation, human immunodeficiency virus (HIV), or for mental health treatment and counseling.

Information to be disclosed:

_____ Diagnosis	_____ Reason for Termination
_____ Medication	_____ Recommendations
_____ Progress & Treatment	_____ Psychiatric Evaluation
_____ Social History	_____ Medical/Psychological Records
_____ Other _____	

The purpose for this disclosure is:

_____ Treatment of Client	_____ Collaboration with School
_____ Collaboration with Physician	_____ To Comply with Court Order
_____ Other _____	

This consent will expire 180 days from the date of signature or as otherwise specified by the following event or condition \_\_\_\_\_.

I understand that I may revoke this consent at any time, except to the extent that action has already been taken.

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.

Information used or disclosed because of this authorization may be further disclosed by the recipient and therefore no longer protected by the federal privacy regulations.

\_\_\_\_\_  
 Signature of Client

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Signature of Parent/Guardian

\_\_\_\_\_  
 Signature of Witness