VALEÑA & ASSOCIATES
CELEBRATING 33 YEARS
CHILD, ADOLESCENT & ADULT PSYCHIATRY

*Dr. Maria A. Valeña*
*Dr. James B. Teague*
*Dena Seifert, FNP*
*Dr. P. Scott Parker*
*Dr. Jeffrey Speiden*

# CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient Name_____ Date of Birth _____

Address_____

I authorize: Dr. Maria A. Valeña, Dr. James B. Teague, Dena Seifert, FNP, Dr. P. Scott Parker, Dr. Jeffrey Speiden

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

The purpose for this disclosure is:

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

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