



## CONSENT TO RELEASE INFORMATION

I, \_\_\_\_\_ hereby authorize the disclosure of any mental  
**CLIENT/PARENT/GUARDIAN**

health, general health, education, or alcohol & drug use information for myself or

\_\_\_\_\_ specifically with and between the following two  
**CLIENT NAME**

(2) parties as described below:

[1]

\_\_\_\_\_  
**THERAPIST NAME**

**Groff & Associates, LLC**  
7425 East 86<sup>th</sup> Street  
Indianapolis, IN 46256-1207

**MAIL:** P.O. Box 502246  
Indianapolis, IN 46250-7246  
**PHONE:** (317) 474-6448 x\_\_\_\_ ext.  
**FAX:** (317) 468-9905

**EMAIL:** \_\_\_\_\_@GroffandAssociates.com

**AND**

COMPANY NAME	CONTACT NAME	FAX NUMBER	
TITLE	PHONE	EMAIL	
STREET ADDRESS	CITY	STATE	ZIP

[2] Specific description of the information to be used or disclosed:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Diagnosis                     | <input type="checkbox"/> Medication              | <input type="checkbox"/> Recommendations      |
| <input type="checkbox"/> Progress and Treatment        | <input type="checkbox"/> Lab Results/Drug Screen | <input type="checkbox"/> Psychiatric Eval.    |
| <input type="checkbox"/> Social History                | <input type="checkbox"/> Educational Assessment  | <input type="checkbox"/> Reason for Treatment |
| <input type="checkbox"/> Psychological Testing Results | <input type="checkbox"/> # of Kept/Unkept Appts. | <input type="checkbox"/> Other: _____         |

[3] The information may be used or disclosed for each of the following purposes:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Court Order              | <input type="checkbox"/> Collaboration with School | <input type="checkbox"/> Client Treatment |
| <input type="checkbox"/> Court Testimony          | <input type="checkbox"/> Collaboration for Program | <input type="checkbox"/> Other: _____     |
| <input type="checkbox"/> Confirmation of Referral | <input type="checkbox"/> At the Request of Client  |   |



**Groff  
& Associates**  
Professional Counseling

- [4] The designated information may be transmitted by mail, fax, electronic mail, or the designated parties may discuss by telephone the content of the information to be released. I understand that the information used or disclosed may be subject to redisclosure by the person(s) or class of person(s) receiving it and no longer protected by the Federal privacy regulations.
- [5] I understand that I may revoke this authorization by notifying Groff & Associates in writing, at the address above, of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any effect on actions all ready taken by Groff & Associates in reliance on this authorization.
- [6] I understand that this information may include information relating to:
  - Acquired Immunodeficiency Syndrome (AIDS)
  - Human Immunodeficiency Virus (HIV)
  - Treatment for drug or alcohol use.
  - Mental and behavioral health or psychiatric care.
- [7] I understand that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, nor my eligibility for benefits. Groff & Associates, may refuse to provide treatment only in circumstances where Groff & Associates provided care to you solely for the purpose of creating protected health information for disclosure to a third party.
- [8] I understand that this authorization will expire in one year.
- [9] I understand that there may be administrative charges associated with the use or disclosure of this information should any information need to be disclosed in writing.

This form must be fully completed before signing.

-----  
SIGNATURE OF CLIENT/PARENT/GUARDIAN

----- / -----  
TODAY'S DATE

-----  
PRINTED NAME OF CLIENT/PARENT/GUARDIAN