PHYSICIAN COMMUNICATION FORM

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450 Wellington Rd
Indianapolis, IN 46260
Phone: 317-872-4158

Physician Name_____
Address_____
_____
Phone_____
Fax_____

Patient Name_____**Birthdate**_____

AUTHORIZATION TO DISCLOSE INFORMATION

I understand that the purpose of this disclosure is to coordinate and facilitate my health care. I also understand that records or information about my mental health or alcohol and drug abuse treatment and psychotherapy are confidential; they are protected by applicable state and federal laws, and cannot be disclosed or redisclosed without my written consent unless otherwise provided for in state or federal regulations. I understand that any information about me concerning AIDS, HIV infection, and AIDS-Related Complex and the performance of any tests, counseling, and the results and treatment thereof cannot be released without my authorization. I understand that I may refuse to sign this authorization, that treatment is not conditioned on it, that I may revoke it in writing at any time except to the extent that action has been taken in reliance on it, and that it will automatically expire 60 days from the date signed.

To patient: Please check one option below: I,_____(name)
A.___Do authorize necessary information to be exchanged by the providers above.

B.___**Do Not authorize <u>any</u> information to be exchanged by the providers above.**

Signature patient or representative_____**Date**_____

_____

FOR THE PROVIDERS:

To the Physician:
Diagnoses_____
_____

Treatment
Plans/Recommendations_____
_____
_____

From the Physician, any information relevant to psychological treatment:_____
_____
_____
_____

Signature: Psychologist_____**Date**_____

Signature: Physician_____**Date: _____**