CONSENT TO RELEASE OF MENTAL HEALTH AND ADDICTION RECORDS

State Form 51128 (R / 10-05) / CW 0045

Reset Form

Name of patient	Telephone number

Address (*number and street, city, state, ZIP code*)

I hereby authorize _____ to (*check one*) ☐ release ☐ receive mental health and / or addiction
(*Name of person, provider, or organization*)

records (*check one*) ☐ to ☐ from:

_____ .
(*Name of person, provider, or organization and address*)

The purpose of the release is:

The information to be released is:

- Pursuant to IC 16-39 regarding the release of mental health records and federal confidentiality rules at 42-CFR Part 2 regarding the release of addiction information:

(1) This consent is subject to revocation at anytime, except to the extent that action has been taken in reliance on the patient's consent.

(2) If not previously revoked, the patient's consent to release mental health and / or addiction information will expire when this date, event or condition met occurs:
_____ .

(3) Unless otherwise specified in a written request under this section, a request for release of mental health and / or addiction records is valid for 180 days after the date the request was made.

(4) This authorization is in effect until the expiration date, event or condition is met and regardless of whether the patient is still receiving services from the provider.

Signature of patient	Date (*month, day, year*)

Typed or printed name of patient

NOTE TO RECEIVER: Any addiction information disclosed to you is protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.