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AUTHORIZATION FOR RELEASE OF INFORMATION

I, ___________________________do hereby consent and authorize Integrated Psychological Center of Indiana (IPCI)

TO DISCLOSE to ____
Name/Address/Telephone Number

The following specific information regarding (self/child's name): ____

___ Admission	___ Discharge Summary	___ Progress Notes
___ Attendance in Treatment	___ Patient Demographic Information	___ Psychological Evaluation
___ Progress in Treatment	___ Treatment Plans	___ Other: ___________________________
___ Prognosis/Diagnosis		

I understand that this information is to be used for the purpose of: ____

___________________________	_______________________________
Patient/Guardian Signature	Witness Signature
___________________________	_______________________________
Printed Patient/Guardian Name	Witness Printed Name
___________________________	_______________________________
Date	Date

I, ___________________________do hereby consent and authorize Integrated Psychological Center of Indiana (IPCI),

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I understand that this information is to be used for the purpose of: ____

___________________________	_______________________________
Patient/Guardian Signature	Witness Signature
___________________________	_______________________________
Printed Patient/Guardian Name	Witness Printed Name
___________________________	_____________________________
Date	Date

Patients may revoke releases at any time by informing my clinician verbally or in writing. Unless otherwise specified by this patient, this release will remain valid for **1 year** from the time of signing.