CUMMINS
Behavioral Health Systems, Inc.

Consumer information: Name and DOB required

Authorization to Release Information Form

6655 East US Hwy 36
Avon, IN 46123
Phone: 888.714.1927
Fax: 317.272.0807

Consumer Information: (Please print)

Last Name: First Name: Middle Initial:

Street Address: City: State: Zip Code:

Phone: Social Security Number: Date of Birth:

Mark boxes

I hereby authorize Cummins Behavioral Health Systems, Inc. to: (Please check and print information)

❑ **Release** information to: ❑ **Obtain** information from: ❑ **Verbally Exchange** information with:

Name & relationship of individual or organization: Phone: Fax:

Your information full address required

Street Address: City: State: Zip Code:

Mark boxes below

I authorize the following information to be released: (Please check all applicable)

❑ Assessment & Treatment Plan ❑ Therapist Progress Notes ❑ MD Progress Notes ❑ Drug Screens
❑ Group Therapy Progress Notes ❑ Psychological Evaluation ❑ Medication List ❑ Discharge Summary
❑ Appointments/Excuse Note ❑ Psychiatric Evaluation ❑ Current Diagnosis ❑ Skills Training Notes
❑ Reports (i.e.: School, Court, DCS, Probation) ❑ Other (Please Specify):

Release for Special Protected Information:

If you do not want Cummins Behavioral Health Systems, Inc. to share information regarding alcohol and/or substance use or communicable disease, please check below.

a. The diagnosis or treatment of alcohol and/or substance use. ❑ No
b. The diagnosis or treatment of AIDS, including the results of HIV tests. ❑ No

Choose at least one purpose

Purpose for Disclosure: (Please check all applicable)

❑ Continuity of Care ❑ To obtain payment for services ❑ Facilitate Treatment Planning
❑ Condition of Court Order ❑ Disability Determination ❑ At the request of the Consumer
❑ Other:

Expiration Date: This authorization will expire in 1 year unless otherwise indicated below.

❑ This authorization will expire upon the following date or condition: _____
❑ This authorization will expire 60 days after termination of services at Cummins Behavioral Health Systems, Inc.

Expiration date

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing. I understand the revocation will not apply to information previously released based on this authorization. Please complete the section below to revoke this authorization to release information.

❑ I am revoking this authorization. Date: Signature:

Redisclosure Notice: If I have authorized the disclosure of my health information to someone who is not legally required to keep it confidential, I understand that it may be redisclosed and no longer protected by Cummins Behavioral Health Systems, Inc.

Refusal to Sign: I understand that I may refuse to sign this authorization, but my refusal to sign may affect the ability of the providers to provide me with the necessary treatment. If I refuse to sign this authorization I will still be seen for treatment unless the sole reason for treatment is to create protected health information for a third party, such as court ordered treatment.

Signature of Consumer: CONSUMER SIGNS/DATE HERE **Date:**

(Minors receiving substance use services must sign the authorization form)

Signature of Legal Representative: LEGAL GUARDIAN OF MINOR SIGNS HERE **Date:**

If signed by Legal Representative, provide the relationship to Consumer: LEGAL GUARDIAN RELATIONSHIP HERE

Witness Signature: **Date:**

_____The release of information was completed by means of video conference or phone during the Coronavirus quarantine. The consumer verbally expressed understanding and agreement to the terms herein.

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❑ Appointments/Excuse Note ❑ Psychiatric Evaluation ❑ Current Diagnosis ❑ Skills Training Notes
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a. The diagnosis or treatment of alcohol and/or substance use. ❑ No
b. The diagnosis or treatment of AIDS, including the results of HIV tests. ❑ No

Purpose for Disclosure: (Please check all applicable)

❑ Continuity of Care ❑ To obtain payment for services ❑ Facilitate Treatment Planning
❑ Condition of Court Order ❑ Disability Determination ❑ At the request of the Consumer
❑ Other:

Expiration Date: This authorization will expire in 180 days unless otherwise indicated below.

❑ This authorization will expire upon the following date or condition:_____
❑ This authorization will expire 60 days past termination of services at Cummins Behavioral Health Systems, Inc.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing. I understand the revocation will not apply to information previously released based on this authorization. Please complete the section below to revoke this authorization to release information.

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Signature of Consumer:_____ **Date:**_____
(Minors receiving substance use services must sign the authorization form)

Signature of Legal Representative: **Date:**

If signed by Legal Representative, provide the relationship to Consumer:

Witness Signature: **Date:**

_____The release of information was completed by means of video conference or phone during the Coronavirus quarantine. The consumer verbally expressed understanding and agreement to the terms herein.

Office Use Only: ❑ File ❑ Release ❑ Obtain Validation Date/Initials: Consumer #: