Counseling on Meridian
8935 N. Meridian St., Suite 103
Indianapolis, Indiana 46260
(317) 846-2444 Fax: (317) 846-2452

PATIENT'S REQUEST FOR INFORMATION DISCLOSURE(s)

I,___________________________, hereby request ________________________ (*therapist*) to release/obtain the following information contained in the patient record of:

_____________________________________ _________________________
(Patient name) (Date of Birth)

____
(Address)

______Diagnosis & Evaluation
______Discharge/Termination Summary
______Alcohol/Drug Related Information
______Psychological Testing
______School Achievement Records
______Entire Patient Record
______Other Pertinent Information
____
____
(Explain)

A copy of the above-identified information should be furnished to/by:

____

____
(Name and address of person or organization)

This information is being requested for the following purpose(s):

______Diagnosis & Evaluation
______Formulation of Court-Ordered Evaluations
______Coordination of Care
______Other:____________________

____
I understand that this Request may be revoked by me by giving such revocation, in writing, to ____________________(*therapist*), and that after doing so no further information will be furnished except to the extent that ______________________ (*therapist)* has already acted in reliance on your signed Request. I also understand that this request will expire after ninety (90) days from the date signed.

______________________________________ ________________________
(Patient, Parent or Guardian) *(Date)*

Please send to my attention marked "**Confidential.**"

_____________________________________ ___________________
(Therapist) *(Date)*