

Andrea Barbour, MA
NPI #1023438892

AUTHORIZATION FOR RELEASE OF INFORMATION
A copy shall be valid as original

Name: _____

Date of Birth: ___/___/___

Address: _____

SS#: _____/_____/_____

City: _____

State, Zip Code _____

I hereby authorize **Andrea Barbour, MA**

to release to obtain

Records To/from:

Name

Address

Phone Number Fax Number

Email Address

Please check information to be released:

- | | |
|---|--|
| <input type="checkbox"/> Initial Assessment and Treatment Plan | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Psychological Evaluation | <input type="checkbox"/> Psychiatric Evaluation |
| <input type="checkbox"/> Diagnosis <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Other: |
| | <input type="checkbox"/> Verbal <input type="checkbox"/> Written |

The purpose for use or disclosure of information:

- Continuity of Care Coordination of Services
 Other: please provide a specific description of the purpose/use for disclosure:

I understand that my records are protected under the Federal Confidentiality Regulation (42 CFR Part 2) and cannot be released or re-released without my written consent unless otherwise provided for in the regulation. I also understand that I may revoke this consent at any time, except to the extent that release has already occurred.

This consent is valid for 90 days from the date signed by the patient or authorized party below, unless revoked by me prior to that date, upon the completion or satisfaction of the event or conditions specified; whichever comes first. A copy of this authorization shall be valid as the original.

Patient/Legal guardian: _____

Date: _____

Andrea Barbour, MA
921 East 86th Street Suite 210B
Indianapolis, IN 46240
Ph 812-764-4931 Fx 317-875-1060

Record Retrieval \$25.00
Charge .25 (per page over
10 pages)
1-2 Day Service \$10.00