Valley Professionals Community Health Center
CARING PROFESSIONALS IN YOUR COMMUNITY.

Behavioral Health Release of Information

777 S Main St, Ste 100
Clinton, IN 47842
P: 765-828-1003
F: 877-223-1011

703 W Park St
Cayuga, IN 47928
P: 765-492-9042
F: 888-625-0294

201 W Academy St
Bloomingdale, IN 47832
P: 765-498-9000
F: 877-694-4734

1702 Lafayette Rd
Crawfordsville, IN 47933
P: 765-362-5100
F: 866-612-1385

727 Lincoln Rd
Rockville, IN 47872
P: 765-569-1123
F: 888-880-1423

1530 N 7th St, Ste 201
Terre Haute, IN 47807
P: 812-238-7631
F: 888-291-5750

4757 S 7th St
Terre Haute, IN 47802
P: 812-234-2289
F: 888-815-1058

601 W National Ave
West Terre Haute, IN 47885
P: 812-244-1515
F: 866-981-2282

Mobile School-Based Health Center P:765-592-6164

Format type: Paper ☐ Electronic ☐

Patient Information: (please print)

Name: _____ Date of birth: _____

Address: _____

Phone number: _____

I authorize Valley Professional Community Health Center (VPCHC) to *release, obtain and verbally* exchange information to the following: (Please print)

Health Care Provider/Facility: _____

Address: _____

Phone number: _____ Fax number: _____

Purpose: The purpose of this release is to assist with the continuity of care and facilitate treatment planning between VPCHC and the Health Care Provider or Facility above.

Mental Health and/or Drug and Alcohol Treatment Records that are authorized to be released:
Please mark all appropriate records:

___ History & Physical	___ Psychosocial Assessment	___ Medications	___ X-rays
___ Psychiatric Notes	___ Psychosocial Eval/Tests	___ Psychological Test Results	___ EKGs
___ Progress Notes	___ Physician Orders	___ Alcohol/Drug Assessments	___ Labs
___ Discharge Summary	___ Treatment Plan	___ Alcohol/Drug Treatment	
___ Group Therapy Notes	___ Psychotherapy Notes	___ Other (please specify): _____	

Expiration Date: This authorization will expire in 365 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 VPCHC.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand is 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.

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 VPCHC.

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 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.

Patient signature: _____ Date: _____

Legal representative signature: _____

Relationship to patient: _____ Date: _____

Witness signature: _____ Date: _____