MERIDIAN PSYCHOLOGICAL ASSOCIATES
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AUTHORIZATION FOR MUTUAL DISCLOSURE

CLIENT NAME: _____ DOB: _____

I hereby authorize _____ and its employees to release and/or exchange information with _____

At (Contact Information/Address):_____

DESCRIPTION OF INFORMATION TO BE RELEASED:

___Initial Evaluation ___Treatment Progress ___Clinical Notes ___Labs

___Psychological Tests ___Discharge Summary ___Diagnosis ___Treatment Plan

___School Records ___Verbal Exchanges

other:_____

THE ABOVE INFORMATION TO BE RELEASED FOR THE PURPOSE OF:

___Diagnosis and evaluation

___Formulation of treatment plan

___Psychological/psychiatric evaluation and assessment

___Comply with court ordered evaluations

other:_____

_____

_____

This authorization is subject to revocation at any time except to the extent that the provider which is to make the disclosure has already taken action in reliance on it. I knowingly and voluntarily waive the State of Indiana provision that this authorization expires in 180 days and specify this authorization remain in effect for one (1) year or revocation in writing, whichever occurs first. The above provider shall not be liable to the undersigned client for any consequences of the disclosure by the provider of information authorized above.

_____ _____

Client Signature Date of Signing

_____ _____

Witness Guardian or Custodial Parent

THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY FEDERAL LAW. FEDERAL REGULATIONS (42 CFR PART 2) PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF IT WITHOUT SPECIFIC WRITTEN AUTHORIZATION OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY SUCH REGULATIONS. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE.