Evansville Psychiatric Associates
Complete Outpatient Mental Health Care

2015 Maxwell Avenue, Evansville, IN 47711
Phone: 812-422-7974 Fax: 1-812-671-0627
Email: faxes+2038119@waitingroomsolutions.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth: _____

Address:_____

Any Previous Name(s): _____ SSN:_____

The undersigned, Patient or Personal Representative of Patient, does hereby request and authorize Evansville Psychiatric Associates to:
(Please check all that apply)

- ☐ Receive records from
- ☐ Schedule and cancel appointments with
- ☐ Release records to
- ☐ Manage billing matters with

The following office or individual:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ FAX:_____
(Note: This release is void unless this section is filled out with the relevant party's information)

For the following purpose: O Patient request, O Coordination of Care, O Legal Purpose, O Billing
(Please check all that apply)

•Offices or individuals that do not share a physical address will each need a separate signed release.
•Medical records may include but are not limited to the following information: described and disclosed demographics, symptoms, history and physical, diagnosis, functional status, treatment plan, medication, psychological test results, psychiatric records, recent lab results, prognosis, attendance, progress, which may include mental health and drug/alcohol information.
•Information shared through this release may be subject to redisclosure.
•This release may be revoked early at any time, by providing a written request to Evansville Psychiatric Associates.
•Refusal to sign this release does not affect ability to obtain treatment, payment for services, or eligibility for benefits, with the exception of treatment dependent upon information from the above party.
•This release will expire 1 year after the signed date, unless specified otherwise below.

This authorization will expire in: O 1 year from last appointment, O 1 year, O other: _____

Signature of Patient / Parent / Guardian: _____

Date: _____