2015 Maxwell Avenue, Evansville, IN 47711
Phone: 812-422-7974 Fax: 1-812-671-0627
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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth: _____ Acct #:_____

Address: _____

Any Previous Name(s): _____ SSN: _____

❍ The undersigned, Patient or Personal Representative of Patient, does here by request and authorize Evansville Psychiatric Associates to **receive records** from:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ FAX:_____

For the following information described and disclosed demographics, symptoms, history and physical, diagnosis, functional status, treatment plan, medication, psychological test results, recent lab results, prognosis, attendance, progress, which may include mental health and drug/alcohol information.

OR

❍ The undersigned, Patient or Personal Representative of Patient, does here by request and authorize Evansville Psychiatric Associates to **release** to:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ FAX: _____

For the following information described and disclosed demographics, symptoms, history and physical, diagnosis, functional status, treatment plan, medication, psychological test results, recent lab results, prognosis, attendance, progress, which may include mental health and drug/alcohol information.

This authorization will expire in ❍ 1 year ❍ 90 days, Date: _____

Signature of Patient / Parent / Guardian: _____

Date: _____