MILESTONES
CLINICAL & HEALTH RESOURCES
WWW.MILESTONESCLINIC.COM
a division of Stone Belt

Authorization for Use of Release of Information

FOR THE RECIPIENT OF THE INFORMATION:

If any of the requested records contain information regarding alcohol or drug abuse treatment, it is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further use or disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the use or release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse patient.

I herby authorize: Milestones, a division of Stone Belt Arc, Inc.

□ 550 S. Adams Street
Bloomington, IN 47403
(812) 333-6324
Fax (812) 331-6700

□ 1531 13th Street
Columbus, IN 47201
(812) 376-6501
Fax (812) 376-6551

To release, or obtain health information and records during the course of treatment of:

PATIENT NAME:_____ Phone:_____
Address:_____ Date of Birth:_____
_____ Social Sec. #:_____

1. The information is to be <u>disclosed to or obtained from</u> the following person(s) or organization:

Practice and/or Person:_____
Address:_____
Phone:_____ Fax:_____

2. **Purpose:** The reason for the use or disclosure is:
□ At the request of the patient / guardian / physician □ Other:_____

3. **Information to be obtained or disclosed:** The information to be used/disclosed includes only those items checked below, with respect to services provided on or around (insert dates of service you would like information disclosed): _____**(if blank, all dates of services will be included)**

□ Intake Report
□ Progress Note(s)
□ Discharge Summary
□ Psychological Testing
□ Billing/Ins Only*
□ Psychiatric Evaluations/Treatment Notes
□ Confirmation of Attendance
□Other (specify):_____

*A release is required for adult patients on parent(s)'s insurance.

Indicate Specific Information to be EXCLUDED from this authorization, if any:
Drug and Alcohol Records □ HIV/AIDS Records □ Infectious Disease Records

This information is limited to only the information that I have requested above to be used or disclosed to the person(s)/facilities named herein. I hereby release Milestones, a division of Stone Belt Arc, Inc. from all legal responsibilities or liability that may arise from the use or disclosure of medical records and other health information in reliance on this authorization. If the patient is a minor, relevant state laws should be followed with respect to the required signatures. Milestones will not condition treatment, payment, or eligibility for benefits on whether or not this authorization is signed.

1. I understand that information used or disclosed in accordance with this authorization may no longer be protected by Federal law, and could be used or re-disclosed by the receiving party.
2. I understand that I may refuse to sign this authorization and that Milestones will not condition treatment on whether or not I sign this authorization.
3. I have the right to stop the use or release of information at any time, although I understand that I cannot do anything about information already used or disclosed under this authorization.
4. I understand that I will receive a copy of this completed form upon request.

Expiration of this Release:
This release will expire upon the patient's 18th birthday if they under 18 at the time of signing, or 4 months after discharge from Milestones, whichever comes first. This release may be revoked at any time.

*Signature:*_____ _____ _____
(Patient, Parent if minor child, or legal guardian) *(Relationship)* *(Date)*

Printed Name:_____