Reset Form

CONSENT TO RELEASE OF MEDICAL, MENTAL HEALTH AND/OR SUBSTANCE USE RECORDS

State Form 51128 (R2 / 4-21)
DEPARTMENT OF CHILD SERVICES

INSTRUCTIONS: The Family Case Manager or DCS representative should present this form to the person from whom the consent to release is being sought, and may assist in its completion if assistance is requested. The person consenting to the release of documents must fully read the completed document and sign in the "Signature of Patient" box below after doing so. A signed copy of this document must be provided to the individual signing the release.

Name of patient	Telephone number ( )
Address *(number and street, city, state, and ZIP code)*	

I hereby authorize _____ to *(check one)* ☐ release ☐ receive
(Name of person, provider, or organization)

medical, mental health and/or substance use records *(check one)* ☐ to ☐ from:

_____
(Name of person, provider, or organization and address)

The purpose of the release is:

The information to be released is:	Dates of service *(month, day, year)*
☐ Medical Records ☐ Mental Health Records ☐ Substance Use Records	From To

NOTE: Federal law requires that, if requesting release of Substance Use Records, an explicit description of the substance use disorder information that may be disclosed must be included below.

Pursuant to IC 16-39 regarding the release of mental health records and federal confidentiality rules at 42 CFR Part 2 regarding the release of addiction information:

1. This consent may be revoked at any time in writing except to the extent that disclosure or action has been taken in reliance on the patient's consent.
2. If not previously revoked, the patient's consent to release medical, mental health and/or substance use records will expire when this date, event or condition is met or occurs (i.e., the closing of the CHINS case):

   _____
3. Unless otherwise specified in paragraph (2) above, this release for medical, mental health and/or substance use records is valid for 180 days after the date that this release is signed.
4. The signing of this release may not be conditioned upon treatment, payment, enrollment or eligibility for benefits, except as allowed under HIPAA regulations.
5. Information used or disclosed pursuant to this release may be subject to re-disclosure by the recipient and may not longer be protected by federal or state law.
6. My signature below indicates that I have read and understand this form and authorize release of my information as described above.

Signature of patient	Date *(month, day, year)*
Typed or printed name of patient	

NOTE TO RECEIVER: Any addiction information disclosed to you 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 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 release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.