Wednesday, November 15, 2023

Indianapolis Release of Information

Inspire Counseling and Support Center/The Transition House, Inc.

Authorization for Release of Confidential Information

I, Matthew Carey Smith hereby authorize Inspire Counseling
insert your name here
and Support Center, The Transition House, Inc. (Inspire/TTHI), to obtain or release information regarding this client from/to the entity listed below. This information may include: medical records, mental health records, substance abuse records, and any other record created as part of my services with Inspire/TTHI.

Please select one or both below:	Release
Entity Name:	Federal Probation
Entity Address:	501 S. 9th St. Nolesville, Indiana, 46112
Entity Phone Number:	(317) 691-1010
Client Name	Matthew Smith
Client Date of Birth	Sunday, September 8, 1968
Information to be Obtained and/or Released	Treatment Recommendations Compliance or non-compliance with program activity Record of attendance & participation in program activity Frequency and results of urine drug screens Inspire/TTHI representative summary notes Medical, mental health, psychiatric, alcohol/drug abuse records ALL OF THE ABOVE

The purpose of obtaining and/or releasing this information: Assessment and treatment facilitation

Authorization: I certify that this request has been made freely, voluntarily, and without coercion and that the information given is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written recovation is effective upon receipt of the Release of Information Unit at the facility housing the records. Re-disclosure of my medical records by those receiving the above-authorized information may be accomplished without my further written authorization and may no longer be protected. Without my expressed revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on (date supplied by client); (3) under the following conditions:

I understand that tmy records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Client Records, 42 CFR part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. For court ordered clients, this information may be re-disclosed for open court per conversation between the treatment provider, judge, and attorneys. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

Release of Information Expiration: On the below date:

Date of expiration: Friday, November 15, 2024

Client Social Security Number: 303-80-6283

Client (or legal guardian) Signature

Date Wednesday, November 15, 2023