6337 Hollister Drive
Suite 101
Indianapolis, IN 46224

INDY psych

Phone: (317) 291-9007
Fax: (317) 536-1830
www.indypsych.com

Permission for the Release of Information

Client's Name: _____

Address: _____

_____

City: _____ State: ____ Zip: _____

Phone: (___) _____

I agree to allow the release and exchange of information about me including written reports, progress notes, and telephone calls, between my therapist at Indianapolis Christian Psychological Services and the person or agency listed below. I understand that this communication may include psychological, social, academic, medical, legal, testing and psychiatric information. I understand that the purpose of this communication is for facilitating my services at IndyPsych. I understand this agreement will be in effect until a period of 90 days following the end of my services with IndyPsych. I also understand that this agreement may be ended at any time by my written notice. I understand a Notice of Privacy Practices is available to me on request.[1]

Please Circle Your Therapist's Name:

Dr. Mark Dobbs Tony Trapp Lori Britton Cheryl Vance

Name: _____
(Outside Agency or Doctors Name Here)

Address: _____

_____

Phone: _____

Signed: _____ Date: _____
(Your Signature is Required)

Witnessed: _____ Date: _____

[1] This notice details our policies and your rights regarding your confidential records.