Dion Short Metzger, M.D.
370 Prospect Place
Alpharetta, GA 30005

September 10, 2012

Dear Patients:

I am writing to advise you that I will be closing my practice as of **November 16, 2012**. You may contact your insurance carrier for referrals of psychiatrists in your area. You can contact your local county mental health center (1-800-715-4225) or may inquire with your primary care provider if they can continue your medication management. You can also call the local hospitals including Peachford Hospital (770-455-3200) and Ridgeview Hospital (770-434-4567) for further referrals of practitioners. I recommend working towards finding your new physican soon to avoid uninterrupted medical care.

I will make a copy of your medical records available to the physician you designate. Since these records are confidential. I will require your written authorization to make them available to your new physician (please include both their phone and fax numbers). For your convenience, I am enclosing with this letter an authorization form for you to complete and return to the office once you have selected a new physician. Assuming I receive your completed authorization form prior to my last day of practice, there will not be a charge for copying your record. If you have any further requests regarding your records after **November 16, 2012**, please send an e-mail to drmetzger.records@gmail.com.

Please contact our office to schedule a visit prior to my departure. As a reminder, no prescriptions can be authorized after **November 16, 2012**.

Thank you for having chosen me as your physician. It has been my pleasure and honor to serve you. Best wishes for your future health.

Sincerely,

Dion Short Metzger, MD

Phone: (678) 393-3374
Fax: (678) 393-9374

AUTHORIZATION FOR USE/RELEASE OF PROTECTED HEALTH INFORMATION

(This form applies only to the release and disclosure of information. It is not consent for treatment or intended for any other purpose.)

1) _____ _____
(Name of Consumer) (Date of Birth)

_____ _____
(Street Address) (City, State, Zip Code)

I authorized the use and/or release of my protected health information as described in Section 4 below. I understand this authorization is voluntary and is made to confirm my instructions.

2). **AUTHORIZATION TO RELEASE FROM:**

_____
Name

_____
Street Address

_____
City, State, Zip

Fax:_____

3). **RELEASE PROTECTED HEALTH INFORMATION TO:**
(Charges may apply)

_____
Name

_____
Street Address

_____
City, State, Zip

Fax:_____

4). **HEALTH INFORMATION TO BE RELEASED FOR THE FOLLOWING DATES:** _____

INCLUDE: ____ ALL MEDICAL RECORDS: (Circle those that are to be released)
(Specifically) Mental Health/Substance Abuse diagnosis; Evaluation Results and Recommendations; Treatment Plan; Treatment progress on counseling goals; Compliance with treatment plan; Drug screen results; Attendance Record; Medication compliance; discharge date and reason for discharge; Continuing Care Recommendations; Lab reports.

_____ Billing Records: (Specify dates, etc.)_____

_____ Verbal Communication/Telephone Calls: (Specify Names) _____

_____ Other: (Please give a clear description or explanation) _____

In compliance with Georgia Statutes that require special permission to release otherwise privileged information, please INITIAL if protected information being released includes:

_____ Mental Health _____ Developmental Disabilities
_____ Alcohol Abuse _____ Drug Abuse
_____ HIV (AIDS) _____ Other: (Specify) _____

5). **PURPOSE OR NEED FOR DISCLOSURE:** (INITIAL all that apply. You must initial at least ONE)

____ Further Medical Care ____ At the Request of the Consumer ____ Legal/Legislative Issues
____ Insurance Eligibility/Benefits ____ Vocational Rehabilitation Evaluation ____ Summary Report
____ Disability Determination ____ Other: (Specify) _____

6). **EXPIRATION:** This authorization becomes effective ____/____/____ and may be revoked by me in writing at any time except to the extent of action already taken. Unless earlier revoked by me, this authorization automatically terminates one (1) year from the effective date. This will expire one (1) year from the date of my signature below. I further understand that if I am under a criminal justice system referral this cannot be revoked by me until there has been a formal and effective termination or revocation of my release from probation or parole or other proceeding under which I was mandated for treatment.

7). **UNDERSTANDING AND SIGNATURE:**

I understand that this authorization does not extend to release of any HIV/Aids information unless I have indicated above. I further understand that the information authorized by this Release will be released to the authorized recipient only for the purpose noted above. I understand that the information used or released as a result of this authorization may no longer be protected by federal privacy laws and may be further used or released by persons or organizations receiving it without obtaining my authorization.
I understand that I am entitled to receive a copy of this authorization. **Copy given to consumer:** _____

_____ _____
Legal Signature of Consumer or Legal Guardian Date

If a representative on behalf of a consumer signs authorization complete the following:

Representative's Name: _____ Relationship to Consumer: _____

(FORM MUST BE COMPLETE) PLEASE SEE REVERSE FOR IMPORTANT INFORMATION

Notice to Recipient: This information has been disclosed to you from records protected by Federal confidentiality rules (42CFR Part 2) and/or state law. In accordance with federal and state law requirements, the information received pursuant to this document is confidential and recipient is prohibited from making further re-disclosure of this information to any other person or entity, or to use it for any purpose other than authorized herein without the written consent of the person to whom "I" pertains or as otherwise permitted by law. 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, prosecute any alcohol or drug patient.