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.

ADDITIONAL INFORMATION REGARDING RELEASE OF HEALTH INFORMATION

Provider recognizes the consumer's right of confidentiality of their health information under federal privacy regulations and Georgia law. The consumer should be aware of the following information when requesting or releasing health information.

- **Right to Refuse to Sign This Authorization:** A consumer may refuse to sign this Authorization and this refusal will not affect the consumer's ability to obtain treatment or payment of claims.
- **Right to Inspect or Copy the Health Information to be Used or Disclosed:** A consumer has the right to inspect or copy the health information they have authorized to be used or disclosed by signing this Authorization form. A consumer may arrange to inspect his/her health information by contacting the office listed below.
- **Right to Receive Copy of This Authorization:** A consumer has the right to receive a copy of the signed Authorization form.
- **Right to Revoke This Authorization:** A consumer has the right to revoke this Authorization at any time by giving written notice of revocation to the Privacy Officer (Clinical Director) listed below. Revocation of this Authorization **will not** affect any action taken in reliance of this authorization before receipt of the written notice or revocation.
- **Multiple Releases of Information:** A consumer may request multiple releases of the information stated on the Authorization form. However, all releases based on this form are limited to records dated up to and including the date of the consumer's signature. A new Authorization is necessary for release of information for care provided after the date of the consumer's signature, unless the authorization specifically states that specific records that will be generated in the future may be released: for example, "Future records of a specific test," or "Future records of specific clinic appointment."
- **Who May Sign This Authorization:**
    1. Generally, all consumers 18 years of age and older must sign for release of their own health information unless the following conditions apply:
        A. The consumer is incompetent
        B. The consumer is disabled and cannot sign the form
        C. The consumer is deceased. (The legal representative of the estate may sign)
    2. All persons signing for release of health information on behalf of the consumer must state their relationship to the consumer and provide proof of legal authority of their capacity to act for the consumer.
    3. Minors: Consumers less than 18 years of age must have the signature of a parent or guardian ad litem to sign for release of their health information. Emancipated minors may sign for release of their health information.
- **Fees for Records:** Provider may charge a reasonable fee for viewing, copying, postage and preparation of records to fulfill this request. All fees are based on the applicable laws governing release of health information.
- **Contact Office:** Requests for release of health information can be directed to the Medical Records Clerk or other appropriate staff representative at the office where the services were provided. All questions regarding federal privacy regulations can be directed to:

Your Provider**:** _____

(Name)
370 Prospect Place
Alpharetta, GA 30005

Mail Requests for Records: Authorization forms that are mailed to your Provider must be notarized unless the form is one that is generated by a federal or state entity (such as Social Security).

Authorization Signed at Office: Unless office staff knows the person signing the form, picture identification will be required at the time the form is signed.

Provider makes every effort to provide records as requested within 10 business days. **Federal law** requires that we respond to requests for records within 30 days. If records are stored off premises, we will provide records within 60 days.