AUTHORIZATION FOR RELEASE OF MENTAL HEALTH RECORD

(Also known as Protected Health Information)

PATIENT NAME: _____ DATE OF BIRTH: _____

On the lines below, I authorize Atlanta Specialized Care to use or disclose information from my mental health record, which may include information about psychiatric diagnosis, treatment and substance abuse issues to:

Name: _____ Organization: _____

Contact Phone: _____ Fax: _____

Address:_____

Dates of Treatment: From_____ To_____

Information to be released: Copies of all medical records History and Reports Progress Notes

Other:_____

Purpose of Disclosure: _____

1. I understand that, unless withdrawn, this authorization will expire 180 days from the date of signature. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying Atlanta Specialized Care at the address indicated above, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the
4. recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit
5. the recipient from disclosing specially protected information, such as substance abuse treatment information and mental health information.
6. I understand that this information may include any history of acquired immunodeficiency syndrome (AIDS); sexually transmitted diseases; human immunodeficiency virus (HIV) infection; behavioral health service/psychiatric care; treatment for alcohol and/or drug abuse; or similar conditions.
7. I acknowledge I have been provided a copy of ASC's Notice of Privacy Practices and any charges that may be associated with this release of information.
8. I acknowledge I have discussed any concerns I may have about the use, release, and disclosure of my health information with the appropriate office personnel at ASC.
9. I understand that I can request a copy of this form after completed and signed.
10. I release ASC from all legal liability that may arise from this authorization.

Federal law states that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is prohibited by the Privacy Rule.

By signing below, I acknowledge that I have read and understand this Authorization.

Patients Signature:_____ Date: _____

If not the patient, state reason for acting in place of patient. _____

Name: _____ Signature: _____

Relationship to patient: _____ Date: _____