Peachtree Family Psychiatry Clinic
1720 Peachtree Street NW, Suite 320
Atlanta, Georgia 30309

BEHAVIORAL HEALTH SERVICES
RELEASE OF INFORMATION

Effective One Year FROM:_____ TO: _____

PARTICIPANT'S NAME (Print): _____ DOB:_____

I AUTHORIZE _____

TO RELEASE INFORMATION TO_____

_____

Specific Organization/Person **Address** **Phone Number**

INFORMATION THAT MAY BE RELEASED:

( )Mental Health/Primary Care: ( ) Presence and Progress in Treatment ( )Assessments ( ) Diagnoses
( ) Recovery Plans ( ) Psychiatric Summary ( )Medication Records
( ) Demographic Information

( )Drug/Alcohol Treatment Information: ( ) Presence and Progress in Treatment ( ) Assessments ( ) Diagnoses
( )Recovery Plans ( ) Psychiatric Summary ( )Medication Records
( ) Demographic Information

( )_____HIV/AIDS Information
INITIALS

☐ Other: _____

REASON: ( ) Provide continuity of care ( ) Compliance with program ( ) Specify _____
( ) Personal Use ( ) Legal Purposes ( ) Social Security/disability ( ) Insurance/Managed Care

DATES OF SERVICE: FROM _____ TO _____

I understand that my health information is protected under the federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2 that re-disclosure is prohibited, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. Parts 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer will be protected by the HIPAA Privacy Law.

1) review and understand the Notice of Privacy Practices;
2) this authorization is subject to revocation at any time, except to the extent that action has been taken in reliance on the authorization;
3) inspect and receive a copy of the material to be released;
4) request restrictions on how my health information is used and disclosed; and
5) receive a copy of this authorization and the Notice of Privacy Practices

This form has been fully explained and I certify that I understand its contents. I understand that (agency) may not condition treatment on obtaining this consent/authorization from me.

_____ _____
Participant's Signature or Oral Consent when physically unable to sign Date

_____ _____
Witness Signature Date