Grace Community Counseling & Social Services, LLC
777 Cleveland Ave SW #301, Atlanta, GA 30315
Phone: 678-508-3552 Fax: 404-762-6210
tgmonroy@gmail.com www.gracecommunitycounseling.com

Authorization to Release Information

Name of Client: _____ **Client Birth Date:** _____

I HEREBY REQUEST AND AUTHORIZE:

Name/Agency: **Grace Community Counseling & Social Services, LLC**
Address: 777 Cleveland Ave SW, #301
Atlanta, GA 30315
Phone: (678-508-3552)

TO:
☐ OBTAIN RECORDS FROM ☐ RELEASE RECORDS TO

Name/Agency: _____
Address: _____
_____
Phone/Fax _____

To disclose the following specific information:

☐Psychiatric Evaluation	☐Psychological Reports	☐Medical Records
☐Psychosocial History	☐Treatment Plan	☐Labs (Drug Screens, etc)
☐Case Records/Reports	☐Discharge	☐Progress in Treatment

☐Other: _____

FOR THE PURPOSE OF COORDINATION OF CARE UNLESS OTHERWISE NOTED BELOW:
_____

I understand that unless otherwise limited by state or federal regulations and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time. This consent can further be terminated in the event that _____ occurs. If not previously revoked, this consent will terminate one year from the date appearing below.

The protected health information authorized to be used or disclosed includes:

_____ **I authorize the disclosure of alcohol and drug abuse information, if any.**
Initials

_____ **I authorize the disclosure of any information concerning testing for HIV (human immunodeficiency virus) and/or treatment for HIV or AIDS (acquired immune deficiency syndrome) and any related conditions, if any.**
Initials

HIPAA/ 45 CFR 160 and 164:
Release of Information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPPA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and imperative guidelines promulgated there under. I understand that information received or medical records prepared after this release form is completed, regarding my condition and the service I have received in the course of my diagnosis and treatment, may be subject to release to authorized parties in compliance with federal and state law and the terms of this form. I understand that information to be released may include information regarding drug abuse, alcohol abuse, psychological/psychiatric/psychosexual impairments, HIV and/or AIDS or physical conditions. I understand that the Federal Privacy Rule (HIPAA) does not protect the privacy of information if re-disclosed and therefore request that all information obtained from this person or agency be held strictly confidential and not be further released by the recipient. I further understand that my eligibility for benefits, treatment or payment is not conditioned upon my provision of this authorization. I intend this document to be a valid authorization conforming to all requirements of the Privacy Rule.

_____ _____
Consumer/Client Date

_____ _____
Guardian Date

_____ _____
Witness Date