AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Medical Record # ____________

Patient Name ____________

Date of Birth ____________ SS# ____________

1. I authorize the use or disclosure of the above mentioned individual's health information as described below: (Please check the appropriate box)

☐ to release to ☐ to obtain from ☐ to communicate with

2. The individual or organization authorized to make the disclosure:

Peachford Behavioral Health System of Atlanta Phone 770-454-2348
2151 Peachford Rd, Atlanta GA 30338 Fax 770-454-2374

3. This information may be disclosed to and used by the following individual or organization: (Please type or print clearly….. …Enter here where records should go)

Name: ____________

Address: ____________

____

Your Contact Phone # ____________

4. Information to be disclosed (Please check the appropriate box):

☐ Face Sheet ☐ History & Physical ☐ Consultation Reports
☐ Discharge Summary ☐ Treatment Plan ☐ Entire Record
☐ Psychiatric Evaluation ☐ Family / Social History ☐ Other: ____________
☐ Psychological Evaluation ☐ Lab & Imaging Results

Records needed for the time …… ADMIT DATE__________ to DISCHARGE DATE ____________
**Only most recent admission will be sent if left blank.

5. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency syndrome (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

6. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management department. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:______________. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

7. I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact India Wallace at 770-454-2348.

8. I understand that there may be **associated fees** for this service and the name & address provided above may be billed unless otherwise instructed. PBHS may contract with a third party vendor for his service.

____________ ____________
Signature of Patient or Legal Representative Date Signed

____________ ____________
If signed by Legal Representative, Relationship to Patient Signature of Witness

REV 6/2012