Georgia Psychological Treatment Center
1640 Powers Ferry Road, Building 20, Suite 200, Marietta, GA 30067
FAX: (404) 891-6467

AUTHORIZATION TO RELEASE INFORMATION (MUST BE COMPLETED IN FULL

Client Name: _____ **Client Phone #:** _____

Client Birth Date: _____ **Client Social Security Number:** _____

I HEREBY REQUEST AND AUTHORIZE: Georgia Psychological Treatment Center ("GPTC")

CHECK ALL THAT APPLY: [ ] TO RELEASE TO: [ ] TO REQUEST FROM:

(NAME OF PERSON/PROVIDER/SCHOOL/FACILITY): _____

(ADDRESS): _____

(CITY):_____ **(STATE):** _____ **(ZIP):** _____

(PHONE): _____ **(FAX):):** _____ **(EMAIL):** _____

I AM AUTHORIZING RELEASE OF THE FOLLOWING INFORMATION:
CHECK APPROPRIATE AREAS TO BE RELEASED – YOU MUST BE SPECIFIC

[ ] FACE SHEET	[ ] PSYCHOSOCIAL HISTORY
[ ] DISCHARGE SUMMARY	[ ] PROGRESS NOTES
[ ] HISTORY & PHYSICAL	[ ] TREATMENT PLAN
[ ] PSYCHIATRIC EVALUATION	[ ] TELEPHONE CALLS/VERBAL COMMUNICATION
[ ] PSYCHOLOGICAL EVALUTION	[ ] LABORATORY/RADIOLOGY REPORTS
[ ] INITIAL CLINICAL ASSESSMENT	[ ] DISCHARGE PLAN
[ ] CONTINUING CARE PLAN	[ ] CONSULTATIONS

[ ] ABSTRACT OF RECORD ONLY (Abstract consists of psychological or psychiatric evaluation, history and physical, discharge summary, psychological evaluation, copying charges DO NOT APPLY)

[ ] OTHER (PLEASE SPECIFY): _____

FOR THE PURPOSE OF (MUST BE COMPLETED) : ( ) CONTINUED TREATMENT ( ) OTHER _____

I understand authorizing the use or disclosure of the health information identified above is voluntary and I need not sign this authorization form to ensure healthcare treatment. I understand that any disclosure of private health information carries the potential for unauthorized re-disclosure and may no longer be protected by federal privacy laws or regulations. I further agree to indemnify and hold harmless GPTC's staff from all liability that may arise from the release of the information herein requested.

I understand that I have the right to inspect or obtain a copy of the health information disclosed. Medical records frequently contain information which may be privileged and/or confidential remarks furnished by the client, the client's family and staff. If, in the judgement of the GPTC staff, disclosure of the privileged/confidential information will be harmful to the client, release of such information may be withheld in accordance with specific state and federal regulations. Records released may contain alcohol and drug treatment information, client photographs, AIDS/HIV or psychiatric/psychological/other mental health privileged or confidential information. Certain communications are privileged and not subject to release without your consent under state and/or federal law.

After giving due consideration to the above statement, I authorize GPTC and/or members of its staff to furnish information, including electronic, photostatic, or faxed copies of my medical record, including matter privileged under the laws of the state of Georgia, and applicable Federal laws and regulations including but not limited to the Health Insurance Portability And Accountability Act (HIPAA), to the above organization/individual, or its agents.

I understand that I have the right to revoke this authorization at any time and that revocation request must be submitted in writing. I understand the revocation will not apply to information that has previously been released in response to this authorization. I understand that 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 is only valid for one (1) year from my signature date, unless I specify another date here: _____

_____ _____
DATE/TIME SIGNED **CLIENT SIGNATURE**

_____ _____ _____
WITNESS SIGNATURE **LEGAL GUARDIAN SIGNATURE IF APPLICABLE** **RELATIONSHIP**

Prohibition on redisclosure; this information may be protected by Federal Regulation (42 CFR Part 2) which prohibits you from making further disclosure. SEPTEMBER 2014