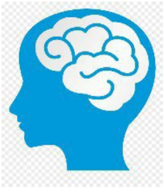

620 Colonial Park Dr
Suite 100
Roswell, GA 30075
P: 678-439-0017
F: 678-884-0761

AUTHORIZATION TO RELEASE HEALTH INFORMATION FOR THERAPIST

Print Name of Patient: ____________
Patient Address: ____________________________________, ____________
____
Date of Birth: ____________ Phone: ____________ Last 4 of SSN:

My Authorization

I authorize the use or disclosure of the above individual's health Information as described below for coordination of care between my providers. My psychiatric provider or provider representative at *Psychiatry and Wellness of Georgia* is authorized to disclose information to my therapist or their representative that is listed below. My therapist or their representative is authorized to disclose information to my psychiatric provider or their representative ___________

Therapist Name	Therapist Address	Therapist Phone Number	Therapist Fax Number

Psychiatric Provider / Practice Name	Practice Address	Practice Phone Number	Practice Fax Number
		(678)-439-0017	(678)-884-0761

The type of information to be used or disclosed is as follows (SELECT ALL THAT APPLY):
Complete treatment records ☐ Demographic Information ☐
Diagnosis and current mental status ☐ Medication Lists / Medications Prescribed ☐

Any specific Information that you do not want shared between providers?

This authorization ends:
- On When the following event occurs:

II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party. I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards. I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this

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authorization. I will receive a copy of this authorization after I have signed it if requested. A copy of this authorization is as valid as the original.

III. Additional Consent for Certain Conditions

This medical record may contain information about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment. Separate consent must be given before this information can be released.

☐ I consent to have the above information released.
☐ I do not consent to have the above information released.

If the patient is a minor or unable to sign, please complete the following: -
Patient is a minor: years of age - Patient is unable to sign because:

Printed Name of Authorized Representative:

Authority of representative to sign on behalf of the patient: -
☐ Parent ☐ - Legal Guardian ☐ - Court Order ☐ - Other:

The CLIENT MUST sign the consent if they are able to do so. The only exceptions are if the client is a minor or has a legal document giving permission for someone else to sign on their behalf.

Client / Clients LEGAL Representative / Parent or Guardian Signature

Date