

The Potter's Behavioral Medicine Clinic

307 Old Stone Rd Villa Rica, GA 30180

770-459-8799

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

CLIENT ✓ _____ DOB _____ SS# _____ ↓

The authorization from implements the requirements for client authorization to use and disclose health information protected by the federal health privacy law. 45 C.F.R. parts 160. 164: the federal drug and alcohol confidentiality law. 42 C.F.R. part 2; and Division protocol No. 3.200-10.

SIGNED AND VALID CONSENT MUST BE IN RECORD FOR ALL INFORMATION RELEASED

I hereby authorize and request The Potter's Behavioral Medicine Clinic to release / Obtain / and/or exchange information with:

Agency/ Individual : _____ ✕

Address: _____ ✓

_____ ✕

This data shall include: (CLIENT/GUARDIAN INITIAL BY EACH APPROPRIATE BLOCK)

The following information for dates of service from _____ ✕ through _____ ✕

- P Admission Assessment /Screening Case Management Assessment/Notes
Social, Family, Medical, Developmental Psychological Evaluation
Substance Abuse, Legal History Psychotherapy Notes
Service Plan/THP/Goal Plan Psychiatric Evaluation/Progress Notes
Needs Assessment School Attendance / Education Info
Discharge Summary HIV/AIDS Info
Admission, Discharge, Treatment Summaries: Medication History/Physicians Orders
Specify: _____ Other (Specify) _____

I understand this information will be used for: (CLIENT/GUARDIAN INITIAL BY EACH APPROPRIATE BLOCK)

- Insurance/Medicaid/Medicare determination of benefits.
In assist in the development of individual service/goal plans.
Provide data to assist with evaluation/assessment/prescriptive services.
Coordination of services between agencies.
To assist in securing benefits from entitlement programs.

Once information is disclosed pursuant to this signed authorization, I understand that the federal privacy law (45 C.F.R. Part 164) protecting health information may not apply to the recipient of the information and , therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure. When we disclose mental health and developmental disabilities information protected by Division Protocol (No. 3.200-10) or substance abuse treatment information protected by federal law (42 C.F.R. Part 2), we must inform the recipient of the information that redisclosure is prohibited without client consent, except as permitted or required by the two laws. Information to be disclosed may include: drug, alcohol, sickle cell anemia, psychological or psychiatric information. Our Notice of Privacy Practice described circumstances where disclosure is permitted or required by the laws.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it (or inless this authorization is given as a condition of obtaining insurance coverage and the insurer has a legal right to contest the policy or a claim under the policy). In any event, if not revoked earlier, this authorization expires automatically within one year from this date unless otherwise specified.

(Expiration Date) _____ ✕

The procedure for revoking this authorization, as well as the exceptions to my right to revoke is detailed in The Potter's Behavioral Medicine Clinic Notice of Privacy Practice, which has been given to me. If you do not have the Notice of Privacy Practice, and would like to see a copy, you may request one from the receptionist or other staff.

I understand that I may refuse to sign this authorization form. I understand that The Potter's Behavioral Medicine Clinic will not condition the client's treatment (or any payment, enrollment in a health plan, or eligibility for benefits) on receiving my signature on the authorization. I certify that this authorization is made freely, voluntarily and without coercion. I understand that health information indicated by my initials will be disclosed.

Client or Legally Appointed Representative (Print Name): _____

✕ Relationship to Client: _____

✕ Signature: _____ Date: _____

✕ Minor's Signature: _____ Date: _____