The Potter's Behavioral Medicine Clinic
307 Old Stone Road
Villa Rica, GA 30180
770-459-8799

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

CLIENT______________________ DOB__________ SS#___________

The authorization form 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 ________

__ Admission Assessment/Screening
__ Social, Family, Medical, Developmental
__ Substance Abuse, Legal Histories
__ Service Plan/THP/Goal Plan
__ Needs Assessment
__ Discharge Summary
__ Admission, Discharge, Treatment Summaries from:
Specify:______________________
__ Case Management Assessment/Notes
__ Psychological Evaluation
__ Psychotherapy Notes
__ Psychiatric Evaluation/Progress Note
__ School Attendance/Education Info
__ HIV/AIDS Info
__ Medication History/Physicians Order
__ 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 Practices 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 unless 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 this 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:** ____________