DISCOVERY COUNSELING AND ASSESSMENT CENTER

*820 Ebenezer Church Road, Suite 110, Sharpsburg, GA 30277*
*420 Thomaston St. Zebulon, GA 30295*
*855-817-2428 (fax) • 404-960-1282 (office)*

**AUTHORIZATION FOR RELEASE OF INFORMATION**

**Name: _____ Date of Birth: _____**

**Client/Patient Authorization**

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, legal/ court records, educational records, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the above identified patient. I authorize these agencies to share information by mail, phone, in person, fax and/or email contact. I understand that these records are protected by Federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request.

**I hereby authorize Discovery Counseling & Assessment, LLC to *release* my protected health information (PHI) to:**

_____

**I hereby authorize Discovery Counseling & Assessment, LLC to *obtain* my protected health information (PHI) from:**

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**Disclosure Scope for PHI Release:**

Disclosure may include the following verbal or written information: (check all that apply)

- Face sheet
- History & physical
- Laboratory/diagnostic testing results
- School information
- Discharge summary Medication records
- Behavioral health/psychological consult
- Psychosocial assessment/Family history
- ER record report
- Psychiatric evaluation
- Substance abuse treatment records
- HIV/AIDS lab results & treatment history
- Progress & Case Notes
- Summary of treatment records & contact dates
- Psychological evaluation/testing results
- Other:_____
- Information necessary to identify, diagnose, prognosis, or treatment for mental health, substance abuse (alcohol/drug use), and any other relevant information for the purpose of treatment.

*1. I understand that the information disclosed pursuant to this Authorization **may** be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws (except as set forth in paragraph 2 below).*
*2. I understand that, pursuant to 42 C.F.R Part 2, alcohol and drug abuse records that I authorize to be disclosed pursuant to this document may not be further re-disclosed without my written consent, except by a court order that complies with the preconditions set forth at 42 C.F.R. 2.61 et seq., or the other limited circumstances specifically permitted by 42 C.F.R. Part 2. Any individual that makes such a disclosure in violation of these provisions may be reported to the United States Attorney and be subject to criminal penalties.*

*3. I understand that my healthcare provider will not condition my treatment, payment, or eligibility for any applicable benefits on whether I provide authorization for the requested release of information. I intend this document to be a valid authorization conforming to all requirements of the Privacy Rule and state law, and understand that my authorization will remain in effect for:*

- The period necessary to complete all transactions on accounts related to services provided to me.
- One (1) year

I understand that unless otherwise limited by state or federal regulation and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time. If client is a minor child, I verify that I am the legal guardian/custodian of this child.

_____ _____

*Signature of Client/Legal Guardian or Legally Authorized Representative* *Date*

_____ _____

*Witness (Title or Relationship to Individual)* *Date*

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**USE THIS SPACE ONLY IF AUTHORIZATION IS WITHDRAWN**

*I hereby revoke this authorization, and will send written notice of my withdrawal of this authorization to the staff of the healthcare provider who is providing services to me at 820 Ebenezer Church Road Sharpsburg, GA 30277. Fax: 855-817-2428.*

_____ _____

Date this authorization is revoked by Individual Signature of Individual or legally authorized Representative