RELEASE OF INFORMATION

NAME____ **DATE OF BIRTH**____________________

Exchange, Use and Disclosure of Health Information

I hereby authorize the use, disclosure and exchange of my individually identifiable mental health, substance abuse, and physical health information **BETWEEN**

The Center for Family Psychiatry 120 Handley Road #310 Tyrone, GA 30290
(Name) (Address)

AND

____
(Name /Address)

Scope and Use of Disclosure

Information that may be exchanged and/or disclosed based on this authorization is as follows (check one):

○ All mental health, substance abuse, and physical health information about me, including any records created or received by the Provider. The information will be communicated via telephone conversations, emails, facsimiles, text messages and mail and may include, if applicable:

- Information pertaining to the identity, diagnosis, prognosis, or treatment for alcohol and/or drug abuse
- Information concerning the testing for HIV and/or treatment for AIDS and any related conditions
- Privileged communications between me and a psychiatrist, psychologist, licensed marriage and family therapist, or licensed professional counselor, or between them concerning my communications with any of them.

○ All health information about me as described in the preceding checkbox, **excluding** the following:

____

○ Specific health information **including only** the following:

____

Purpose of Use and/or Disclosure

The purpose for this disclosure is specifically for the following:

____

Expiration: _______________

Other Important Information:

1. I understand that The Center for Family Psychiatry cannot guarantee that the recipient of this information will not re-disclose this information to a third party. The recipient may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of treatment information about a consumer in an alcohol or drug abuse program, the recipient is prohibited under federal law from making any further disclosure of such information unless further disclosure is expressly permitted by written consent of the consumer or as otherwise permitted by federal law governing confidentiality of alcohol and drug abuse patient records (42CFR, Part 2.)
2. I understand that I may revoke this authorization, in writing, at any time except that the revocation will not have any effect on any action taken by The Center for Family Psychiatry in reliance on this authorization before written notice of revocation is received.
3. I release The Center for Family Psychiatry from all legal liability that may arise from the release of the information requested.

X ________________ / ________________ / ________________
(Client Signature) (Date) (Parent/Guardian Signature) (Date) (Witness Signature) (Date)

USE THIS SPACE ONLY IF CONSUMER WITHDRAWS CONSENT

________________________ ________________________
(Date this consent is revoked by Client) **(Signature of Client)**