



Behavioral Health Services of Atlanta

External Release of Information Request

For Disclosure of Mental Health Treatment Information

I, _____ whose Date of Birth is _____, authorize Behavioral Health Services of Atlanta, LLC, to disclose to and/or obtain from _____ the following information:

Description of Information to be Disclosed (Patient/Client should initial each item to be disclosed)

- | | |
|--|--|
| <input type="checkbox"/> Assessment | <input type="checkbox"/> Diagnosis |
| <input type="checkbox"/> Psychosocial Evaluation | <input type="checkbox"/> Psychological Evaluation |
| <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Treatment Plan or Summary |
| <input type="checkbox"/> Current Treatment Update | <input type="checkbox"/> Medication Management Information |
| <input type="checkbox"/> Presence/Participation in Treatment | <input type="checkbox"/> Nursing/Medical Information |
| <input type="checkbox"/> Educational Information | <input type="checkbox"/> Discharge/Transfer Summary |
| <input type="checkbox"/> Continuing Care Plan | <input type="checkbox"/> Progress in Treatment |
| <input type="checkbox"/> Demographic Information | <input type="checkbox"/> Psychotherapy Notes |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Other _____ |

Purpose

This information may be used or disclosed in connection with mental health treatment, payment, or healthcare operations. If the purpose is other than as specified above, please specify:

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Anthea M. Johnson, MS., LPC at Behavioral Health Services of Atlanta, LLC.

I further understand that a Revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization expires on the following date: _____ or as otherwise indicated:_____

Form of Disclosure Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I will be given a copy of this authorization for my records.

Signature of Patient/Client Date

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

Signature of Staff Witness Date
