ADVANTAGE
AUTHORIZATION for RELEASE
of Protected Health Information

*****Legal: ALL ENTRIES MUST BE COMPLETED IN ORDER FOR THIS AUTHORIZATION TO BE EFFECTIVE*****
This form shall NOT be altered, amended, or modified from its original form without express written consent from Advantage

_____ Name of Client _____ Date of Birth XXXX – XX - _____ Social Security Number (last 4)

I Hereby Authorize: **ADVANTAGE BEHAVIORAL HEALTH – 250 North Avenue, Athens, GA 30601**
Phone: 706-389-6789 **MEDICAL RECORDS FAX #: 706-389-6775**

TO: ___Release information to ___Obtain information from ___Talk face to face with ___ Have phone contact with

THE FOLLOWING: _____
(Individual/Agency/Physician/Attorney/Other)
_____
(Street Address)
_____
(City, State, Zip Code) (*FAX number)

For the Purpose of: Healthcare Legal Other: _____

Disclose material from *Date(s) of Treatment*:_____ ***(dates required)***

_____ Diagnosis _____ Initial Evaluation _____ Individual Service Plan _____ Progress Notes

_____ Medication(s) _____ Discharge Summary Other:_____

I understand that:
1. I am not required to sign this authorization in order to receive treatment, and it will not affect my payment status.
2. Disclosure of health information is voluntary.
3. Any disclosure of information carries with it the potential for an unauthorized re-disclosure.
4. Per federal law (42 CFR 2.32), alcohol and drug abuse records that I authorize to be disclosed per this document may not be further re-disclosed without my written consent.
5. I may inspect or obtain a copy of the information described on this form if I request it, unless otherwise prohibited by law.
6. I may refuse to sign this authorization.
7. I get a copy of this form after I sign it.
8. I may revoke this authorization in writing at any time and present my written revocation to Advantage.
9. The revocation will not apply to information that has already been released in response to this authorization.
10. If I have any questions about the disclosure of my protected health information, I can contact the ABH Privacy Officer.

I understand that this form authorizes the release of medical records **including psychiatric, psychological, or other mental health records. I understand that I must enter *my initials below* to authorize the release of *any of the following*:**

(Initial) _____ I authorize the release of ***drug or alcohol diagnosis and/or treatment*** information.

(Initial) _____ I authorize release of information concerning ***treatment and testing for HIV/AIDS*** or other statutorily-protected disease.

(Initial) _____ I authorize the release of my protected health information *to the* ***Court***.

(Initial) _____ I authorize Advantage Behavioral Health *clinician(s) to* ***testify*** about my treatment in legal proceedings/***Court***.

(Initial) _____ I authorize the release **of *Individual Therapy*** notes from my treatment record.

I have read the above and authorize the disclosure of the protected health information as stated. If I fail to specify an expiration date, this authorization will expire one (1) year from the date of signature. Alternate Expiration Date: _____

_____/_____ _____
Signature of Client or Legal Representative Relationship to client **Date** of Signature

_____ _____
Signature of Witness **Date** of Signature

For REVOCATION ONLY-

This Authorization REVOKED on (sign and date): _____ _____
(Signature of Client/Legal Representative) (Date of Signature)