



ATHENS BEHAVIORAL MEDICINE

1361 Jennings Mill Road, Suite 201, Bogart, Georgia 30622
Phone: 706-316-1908 Fax: 706-316-2062

Request/Authorization to Release/Share Confidential Records and Information

I _____, give my permission to Dr. Emily MacKillop, and the person(s) listed below to exchange Information and/or records regarding myself or dependents. I give permission for a faxed or photocopied signature to serve as an original regarding this release. The purpose of this release is to share/release information for the benefit of patient diagnosis, treatment planning, cognitive evaluation, continuity of care, family medical leave, disability requests, and/or benefit claims for life/health Insurance application. The information released pursuant to the authorization may be subject to re-disclosure by the recipient and not longer protected by the privacy act.

1. _____
2. _____
3. _____
4. _____

Release of records pertaining to:

- | | |
|---|---|
| <input type="checkbox"/> Mental health evaluation, treatment, or care | <input type="checkbox"/> Rehabilitation program development or services |
| <input type="checkbox"/> Treatment planning | <input type="checkbox"/> Intake and discharge summaries |
| <input type="checkbox"/> Medical history and evaluation(s) | <input type="checkbox"/> Neuropsychological/Psychological Evaluations: |
| <input type="checkbox"/> Mental health evaluations | <input type="checkbox"/> Developmental and/or social history |
| <input type="checkbox"/> Educational records | <input type="checkbox"/> Progress notes, and treatment or closing summary |
| <input type="checkbox"/> Other: _____ | |

Drug and alcohol information contained in these records will be released under this consent unless indicated here:

- Do not release drug and alcohol information.

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the likely consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within one year, except to the extent that action based on this consent has already been taken. This consent will expire automatically after one year from the date on which it is signed, or upon fulfillment of the purposes stated above, unless otherwise stated.

Signature of client	Printed name	Date
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Signature of parent/guardian/representative	Printed name	Relationship	Date
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I witnessed that the person understood the nature of this request/authorization and freely gave his or her consent, but was physically unable to provide a signature.

Signature of witness	Printed name	Date
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