Release of Information Form

Last Name: _____ First Name: _____ MI: _____

Birthday: _____

1 Alliance Counseling & Psychotherapy Services, LLC. Is hereby authorized to: ☐ Release to: ☐ Receive from:

Name or general description of Person, Agency, or Institution:

_____

Relationship (e.g., Psychiatrist, Former therapist, Father, Mother, Partner):

_____

Address & Contact Information

Street Address (No PO Boxes): _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Please clearly specify information to be released:

☐ Entire Medical Record (excluding Psychotherapy notes and third-party information)

☐ Medication List ☐ Biopsychosocial / Initial Assessment ☐ Diagnosis

☐ Summary / Abstract ☐ Verbal Communication ☐ Billing / Financial Records ☐ Discharge Summary

☐ Progress in Treatment ☐ Verification of Attendance / Treatment ☐ Pathology / Lab Reports

☐ Progress Notes (specify time period if not during entire course of treatment): _____

☐ Other (please specify): _____

This information is requested/released for the purpose of:

☐ Continuity / Coordination of Treatment ☐ Patient Request ☐ Billing or Insurance Claims

☐ Other (please specify): _____

If information to be released includes or may include information regarding treatment or referral for treatment for substance abuse, or information which may be classified as Aids Confidential Information under Georgia Law, disclosure must be specifically authorized. Please note this authorization does NOT permit release of psychotherapy notes.

I understand the federal Privacy Rule ("HIPPA") does not protect the privacy of information if re-disclosed, and therefore request that all information obtained from this person or 1 Alliance Counseling & Psychotherapy Services, LLC be held strictly confidential and not be furthered released by recipient. I further understand that my eligibility for treatment or payment is not conditional upon my provision of this authorization. I intend to this document to be a valid authorization conforming to all requirements of the Privacy Rule for a period of 1 year from the signed date unless otherwise noted.

I understand that I may revoke this authorization by submitting a written request to 1 Alliance Counseling & Psychotherapy Services, LLC at 5755 North Point Parkway Suite 101 Alpharetta GA 30022.

Notice to Receiving Agency or Individual: Disclosure or receipt of the information authorized does not remove any privilege or right of confidentiality with respect to the information and does not authorize re-disclosure of the information. If any of the disclosed information relates to treatment or referral for treatment of substance abuse the following notice shall apply: This Information has been disclosed to you from records protected by Federal Confidentiality rules (CFR Part 2). The Federal Rule prohibits you from making any further disclosures unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

_____ _____

Signature of Client or Responsible Party Date