Paraclete Counseling Center
3905 Johns Creek Ct., Suite 260
Suwanee, GA 30024
revised 4/2009

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Name of Patient _____ Date of Birth_____

I hereby authorize _____

☐ To release to ☐ To obtain from ☐ To communicate with

_____
(Name of person or organization)

_____

_____
(Address, if applicable)

The following information (check appropriate box):

- ☐ Admission or discharge summaries
- ☐ Inpatient or outpatient treatment records
- ☐ Psychological or psychiatric evaluations, reports, assessment, treatment notes or summaries
- ☐ Treatment, recovery, rehabilitation, or aftercare plans
- ☐ Social, family, educational and vocational histories
- ☐ Social work assessments and plans
- ☐ Progress or case notes
- ☐ Evaluations and reports of consultants
- ☐ Information about how the patient's condition(s) affects or has affected his or her ability to work, complete tasks or activities of daily living
- ☐ Billing records
- ☐ Academic and educational records, including achievement and other tests' results, reports of teachers observations, and all other school or special education documents
- ☐ Complete copy of medical record
- ☐ Other _____

The information is needed for the purpose of:

- ☐ Continued treatment
- ☐ Utilization Review
- ☐ Consideration of Payment
- ☐ Coordination of Care
- ☐ Medication Consultation
- ☐ Consultation Purposes
- ☐ Other: _____

After giving due consideration to the extent of this release, I authorize Paraclete Counseling Center to furnish information, including photo static copies of my psychological records concerning my treatment, to the above individual or organization. I further agree to indemnify and hold harmless Paraclete Counseling Center from all liability that may arise from the release of the information herein requested. I understand that I do no have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from Paraclete Counseling Center. I understand that I may inspect the health information described in this authorization.

I understand that I can revoke or cancel this authorization in writing at any time. If I do this, it will prevent any releases after the date it is received but cannot change the fact that some information may have been sent or shared before that date. This authorization will be valid and in effect until _____ (date).

I affirm that everything in this form that was not clear to me has been explained to me, and I believe I now understand all of it.

_____ _____
Patient Date

_____ _____
Parent/Guardian Date

_____ _____
Witness Date