



2308 Perimeter Park Drive
Suite 100
Atlanta, GA 30341

Atlanta Psychological Services, LLC

770-457-5577
Fax 770-457-5599
atlantapsychological.com

rev 10-13-18

CONSENT & AUTHORIZATION TO RELEASE INFORMATION

I, **(print your name)** _____, authorize my clinician to disclose to, and obtain from, another person, information about me, including personal information, mental health information, and other relevant Protected Health Information (PHI) mental health information in the course of providing psychological services.

(print your Atlanta Psychological Services clinician's name) _____

(print name of person to receive or send information to clinician) _____

(Method of communication can include any appropriate method [encrypted email, verbal, US mail, fax] unless otherwise specified to your clinician.)

I am authorizing the release for the purpose of: psychological evaluation psychotherapy

(other reason) _____

This consent and authorization to release information pertains to **(check one)**:

ME or MY CHILD, _____ (date of birth _____):

I understand that this will include information relating to (check and initial if applicable):

- All records and information (no exclusions)
- Mental Health Information and/or General Medical Information
- Alcohol/Drug Treatment HIV-Related Information
- I authorize the release of any records that have been obtained by my clinician from other providers.

Affirmation of Release: I give my clinician permission to release only the information I have selected on this form to the individual or agency I have named and only for the purposes designated. I understand that this release is valid up to one year from the date I sign it and I may refuse to sign this authorization. I may revoke this authorization at any time per the Privacy Rule, the revocation must be in writing, and it will take effect on the day it is received in writing. Any revocation or refusal to sign this authorization will not affect my ability to obtain treatment or payment or my eligibility for benefits. As a patient I have the right to access my treatment records as allowed by HIPAA. Copies of the records may be obtained with reasonable notice and payment of copying cost. I understand that if the person or entity that receives the above specified information is not a health care provider, health plan or health care clearinghouse covered by the federal privacy regulations or a business associate of these entities, the information described above may be re-disclosed and no longer protected by the regulations. I understand that any information disclosed pursuant to this release of information might be subject to re-disclosed and might no longer be protected by the Privacy Rule.

Expiration Date: _____

(for adults) Client's Signature: _____ Date: _____

(for children) Parent's/Legal Guardian's Signature: _____ Date: _____