Atlanta Stress Center, LLC
160 Clairemont Avenue, Suite 200
Decatur, Georgia
470-296-1636

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name:_____ Date of Birth: _____

I authorize Atlanta Stress Center to disclose/receive the health information as directed below.

Receiving Party (eg. previous physician, psychiatrist, therapist, hospital, or other treatment provider)

Name: _____

Address: _____

City: _____State: _____Zip Code: _____

Telephone Number: _____Fax Number: _____

Description of Health Information to be disclosed: _____

Purpose of this use/discloser: ___ At the request of the individual __ Other _____

Expiration of authorization
Unless I request in writing otherwise, I understand that this authorization will expire 1 year from the date on which I signed this authorization.

Right to revoke authorization
I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Atlanta Stress Center office. I understand that the revocation will not apply to any health information that has already been released in response to this authorization.

Re-disclosure
I understand that if my health information is disclosed to a party other than a health care provider, health plan or health care clearinghouse subject to the federal privacy regulations, my health information disclosed pursuant to this authorization may no longer be protected by the federal privacy regulations.

Fees
I understand that federal and state laws allow a fee to be charged for the copying of patient records and I will be responsible for the payment of such fees.

Refusal to authorize use/disclosure
If I have been asked to sign this form in order to authorize the disclosure of my health information for purposes related to research, or for other reasons, I understand that Atlanta Stress Center, LLC may decline to treat me if I refuse to sign this authorization only if: (1) the treatment would be related to a research project and this authorization is for the use or disclosure of my health information such research; or (2) the treatment would be for the sole purpose of creating health information for disclosure to a third party (such as a workers compensation examination).

Release and Waiver
If the health information that I have requested Atlanta Stress Center, LLC to disclose contains any privileged psychiatric or psychological information related to the treatment of **physical and/or mental illness, chemical dependency or alcohol abuse, or testing or treatment of any communicable or infectious disease such as acquired immunodeficiency syndrome (AIDS), Immunodeficiency Syndrome Related Complex (ARC), human immunodeficiency virus (HIV), Venereal Disease, Tuberculosis, or Hepatitis**, I hereby waive any privilege concerning such information for the purpose(s) of releasing it to the party or parties authorized above. I also release Atlanta Stress Center, LLC, their agents and employees from any and all liabilities, damages and claims, which might arise from the release of the health information authorized by me above.

Signature of Patient or patient's representative_____

Date_____