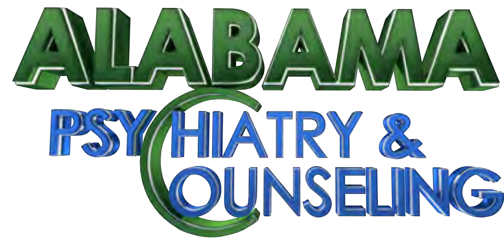

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

This completed form authorizes and requests Alabama Psychiatry and Counseling to release the following patient's information:

Patient's Name: DOB: SS#:

I, the undersigned, authorize and request Alabama Psychiatry and Counseling to release the following, specific, patient information (include dates of service, type of service, etc.):

1.

2.

3.

4.

I understand that this authorization will result in the release of clinical information regarding the patient's diagnosis, behavioral or mental health condition, substance abuse history, and psychiatric and/or counseling services. I understand that these records are strictly confidential and solely for the information of the person to whom addressed.

This information is to be released to (specific name and address):

I also authorize Alabama Psychiatry and Counseling to discuss the patient information with the above named person and/or facility.

This information is to be released for the specific purpose(s) of (if authorization requested by the patient, put" at the request of the individual"):

2015 Stonegate Trail, Suite 105, Vestavia, AL 35243 Phone: (205)440-6292 Fax: (205)313-3177

This authorization is valid for one year from the date listed below. You may revoke this authorization at any time by notifying Alabama Psychiatry and Counseling in writing, but such revocation will have no effect on disclosures of information already under this authorization prior to receipt of the revocation. This authorization is voluntary and you may refuse to sign the authorization and the patient's treatment or payment obligations will not be affected by this authorization unless (1) the treatment is related to research and the use and/or disclosure is related to such research, or (2) the treatment is solely for the purpose of creating protected health information for disclosure to a third-party. Upon signature, you may receive a copy of this authorization. The
information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by state or federal law. ALABAMA PSYCHIATRY ANO COUNSELING will not receive financial compensation or remuneration in exchange for the use and/or disclosure of the patient's information unless an applicable legal exception applies. This authorization is continuing in nature and is to be given full force and effect to release any and all of the foregoing information learned or determined after the date here of until the expiration date. I hold ALABAMA PSYCHIATRY ANO COUNSELING, its employees, directors, officers, agents, and representatives harmless from any and all damages which might result to myself, the patient, our representatives, heirs, and/or assigns from the disclosure of this information. A copy or facsimile of this authorization shall be valid and effective, just as the original.

Patient Signature	Patient Name	Date
Parent/Patient Representative Signature (if applicable)	Printed Name and Relationship	Date
Witness Signature	Witness Name	Date

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