

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** _____ **Phone #:** _____
 (please print)

I authorize: Lake Bridge Behavioral Center / Macon GA Closed Facility - UHS processes Medical Records Requests	
To <input type="checkbox"/> obtain information from	<input type="checkbox"/> release information to

Name of Person or Entity	

Address	

City	
Phone # _____	Fax # _____

My initials below signify that I consent for the following type(s) of information to be released to the above individual/entity.

- Drug/Alcohol Abuse Psychiatric conditions
 HIV or AIDs related information Medical conditions

Do **not** release the following: _____

Treatment Dates: _____

Information that may be released:

- | | | |
|--|---|---|
| <input type="checkbox"/> Medication Record | <input type="checkbox"/> Physician's Psychiatric Evaluation | <input type="checkbox"/> Physician's Progress Notes |
| <input type="checkbox"/> History and Physical Exam Report | <input type="checkbox"/> Lab Results | <input type="checkbox"/> Nursing Progress Notes |
| <input type="checkbox"/> Discharge Plan/Continuing Care Plan | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Psychotherapy Progress Notes |

Other assessments: Nursing Psychosocial Intake Substance Abuse Other (specify) _____

PURPOSE FOR WHICH INFORMATION IS TO BE USED:

- Continuing Care School Disability benefits
 Legal Personal Employment conditions

If for legal purposes, give specific reason: (must be completed) _____

AUTHORIZATION:

I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Revocation must be in writing. Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure. Refer to the Notice for Privacy Practices regarding authorized disclosures. A legible copy of the Authorization or my signature thereon may be used with the same effectiveness as an original.

OTHER CONDITIONS:

This information has been disclosed to you from records whose confidentiality may be protected by Federal Law:

"Federal regulation (42 CFR, Part 2) prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient." [RM 203, 7.2] Rev. 4-12-04

This consent expires one year from the date below unless otherwise specified: (cannot exceed one year) _____

Signature of Patient **Date** **Signature of Parent/Guardian, if applicable** **Date**

Witness, if applicable **Date**

Revocation: I hereby revoke the above authorization: Signature _____ **Date** _____