Atlanta Behavioral Medicine, Inc

HIPAA Privacy – Release Form

Patient Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

****1. Authorization**** I authorize the following provider(s):

☐ Mohammad Ahmad, M.D ☐ Christine Cantilena Barnes, LPC ☐ Viviene Smith, FNP-C

to request and/or release the disclosure of the protected health information described below **to and/or from** the following individuals' organizations

Name of Person/Practice/Organization: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone #: _____ **Fax #:** _____

Name of Person/Practice/Organization: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone #: _____ **Fax #:** _____

****2. Effective Period**** This authorization ends:

☐ On Date: _____
☐ In 90 days from the date signed

****3. Extent of Authorization****

☐ I authorize the release of my complete health record
☐ Psychiatric evaluation.
☐ Progress notes.
☐ Psychotherapy notes.
☐ Lab studies.
☐ Other: _____

I understand that Atlanta Behavioral Medicine Inc. cannot guarantee that the recipient of this information will not disclose this information to a third party. The recipient may not be subject to federal laws governing privacy of health information. However if the disclosure consists of treatment information about patient or as otherwise permitted by the federal law governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2). I understand that except when I am receiving health care solely for the purpose of creating information for disclosure to a third party, I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from Atlanta Behavioral Medicine Inc. I understand that I may revoke this authorization in writing at any time, except that the revocation will not have any effect on any action taken by Atlanta Behavioral Medicine Inc. in reliance of this authorization before written notice of revocation is received (See notice of privacy practices)

Patient/Guardian Signature _____ **Date:** _____

Printed name of Patient/Guardian _____