CAPS-Atlanta

2255 Cumberland Pkwy, #1600-150
Atlanta, Georgia 30339
Phone: 404.419.7895 Fax: 404.419.7891
E-Mail: capsatlanta15@gmail.com
Web: www.capsatlanta.com

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Client Name:_____ Address:_____

I, or my authorized representative, request that health information regarding my care and treatment as set forth on this form: In accordance with Georgia State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT,** and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 8(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 8(a), I specifically authorize release of such information to the person(s) indicated in Item 7.
2. If I am authorizing the release of HIV-related, alcohol, or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. In addition to communication permitted under applicable law, this authorization authorizes you to discuss my health information or medical care with the individuals specified in item 7.
7. Name and address of health provider or entity to reciprocally release and receive this information:

_____

And **Counseling And Psychological Services-Atlanta; 2255 Cumberland Pkwy, 1600-150 Atlanta, GA 30339**

8(a). Specific information to be released include Medical Record, including client histories, office notes (except psychotherapy notes), test results, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
Include: (Indicate *by Initialing)* _____ **Alcohol/Drug Treatment**_____ **Mental Health Information** _____ **HIV-Related Information** (b). By initialing here _____ I authorize the reciprocal release of information between the individuals/entities listed in Item 7 above.
9. This authorization will expire when I revoke authorization or in one year of signature date.
10. if not the client, name of person signing form: _____
11. Authority to sign on behalf of client/ relation to client:_____
All Items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Signature of Client or representative authorized by law:_____Date: _____