Riverside Counseling and Professional Development, LLC

**2774 Cobb Parkway NW, Suite 109 – 454 Kennesaw, GA 30152 | PH (470) 301-9882**

**BEHAVIORAL HEALTH SERVICES RELEASE OF INFORMATION**

**Effective One year FROM: TO:**

**PATIENT’S NAME (Print):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **I** **AUTHORIZE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OR Riverside Counseling and Professional Development, LLC TO**  **RELEASE or**  **OBTAIN INFORMATION TO/FROM:**    **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Specific Organization/Person Address**    **INFORMATION THAT MAY BE RELEASED:**  Mental Health/Physical Information: Presence and Progress in Treatment Assessments Diagnoses  Tx/Recovery Plans Psychiatric Summary Medication Records  Demographic Information    Drug/Alcohol Treatment Information: Presence and Progress in Treatment Assessments Diagnoses  Tx/Recovery Plans Psychiatric Summary Medication Records  Demographic Information  HIV/AIDS Information  **INITIALS**     Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    **REASON:** Provide continuity of care Compliance with program Specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Personal Use Legal Purposes Social Security/disability Insurance/Managed Care    **DATES OF SERVICE: FROM \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_TO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

I understand that my health information is protected under the federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2 that re-disclosure is prohibited, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. Parts 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer will be protected by the HIPAA Privacy Law. I further understand that I may: 1) review and understand the Notice of Privacy Practices; 2)this authorization is subject to revocation at any time, except to the extent that action has been taken in reliance on the authorization; 3)inspect and receive a copy of the material to be released; 5) request restrictions on how my health information is used and disclosed; and 6) receive a copy of this authorization and the Notice of Privacy Practices

**This form has been fully explained and I certify that I understand its contents.** I understand that Riverside Counseling and Personal Development, LLC may not condition treatment on obtaining this consent/authorization from me.

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| Patient’s Signature or Oral Consent when physically unable to sign  “I understand the nature of the release and freely give oral consent” |  | Date |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Signature of Authorized Person in lieu of Patient  Power of Attorney; Guardianship Order |  | Date |
|  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Witness Signature Date Oral Consent/Witness Signature Date