Atlanta Psychiatric Specialists, P.C.

1720 Peachtree St. NW, Ste. 333
Atlanta, GA 30309
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AUTHORIZATION FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION

(PLEASE COMPLETE THE AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION FORM IN ITS ENTIRETY. INCOMPLETE FORMS WILL BE RETURNED TO THE SENDER. SEE REVERSE FOR INSTRUCTIONS ON COMPLETING THIS FORM)

Patient Name: ________________________________ **DOB:** ________________

Patient Address: ____

City: ____________________________ **State:** _____ **Zip:** ________________

Phone (if we need to reach you regarding this request): ______________________

The purpose of this release is for: □ Continuation of care □ Coordination of care □ Legal
□ Disability □ Other: ________________

This release authorizes **Atlanta Psychiatric Specialists, PC to (check one):**
□ Disclose information to individual or entity named below
□ Receive information from individual or entity named below
□ Authorize communication with an individual or entity named below

Name of individual or entity: ____

Address: ____

City: ____________________________ State: _________ Zip:______________

Phone :__________________________ Fax: __________________________

Specific information to be disclosed (check all applicable items to be released)

□ Complete Chart	□ Discharge Summary
□ Medication Records	□ History and Physical
□ Lab Reports	□ EKG/ECG Tests
□ Progress Notes	□ Other (please specify): ______________________

The disclosure of mental health treatment records, substance use records, and records relating to diagnosis or treatment of HIV/AIDS are subject to additional disclosure requirements. Specific consent for release of these records must be provided by the patient or authorized representative. If you consent to release of this information (if applicable) please check the appropriate box and initial on the line:

□ Mental health records **Initial:** _____	□ Treatment for substance use **Initial:** _____	□ HIV/AIDS diagnosis or treatment **Initial:** _____

____ ________________________
(Signature of Patient or Authorized Representative) (Date)

____ ________________________
(Relationship to patient if not self) (Date)

Instructions for Completing the Authorization for Disclosure of Personal Health Information:

- The patient or legally authorized representative must sign and date the form. We may request proof of identity and legal guardianship if an authorized representative signs this form.
- Records will be mailed or faxed directly to the party listed as the recipient on the authorization form within **30 days of receipt of this form**.

Notes on Disclosure of Mental Health Records:

- There are additional restrictions on the release of mental health records. Please review our Notice of Privacy Practices for more information on your rights and responsibilities regarding medical records or personal health information stored at this office.

Records Request Fees:

- If the records are needed for continuing care purposes and are sent directly to a physician or other healthcare facility, the records will be provided free of charge. If we are unable to fax the records, we may charge a fee to recover our costs for mailing the records.
- Records requested for the purpose of completing an application for Social Security Disability will be provided free of charge, in accordance with state law.
- Records requested for all other purposes are subject to copying charges in accordance with applicable state law. You will be notified of any applicable fees before the request is completed and you may withdraw your request without penalty.

Revocation and Expiration of Authorization:

- This authorization may be revoked at any time, except to the extent that action has already been taken to comply with this request.
- This authorization will automatically expire six (6) months from the date signed unless revoked in writing.

Denial of Request for Release of Medical Records:

- Requests for release of medical records are reviewed individually. We may deny a request under limited circumstances provided for under state or Federal law. We will notify you of an adverse decision regarding any request to access or obtain a copy of the requested information within thirty (30) days of receiving this request if the information is maintained or accessible on-site or within sixty (60) days if the requested information in not maintained on-site. If we are unable to comply with a request within the specified timeframe, we may extend the applicable deadline for up to thirty (30) days by notifying you in writing.
- If we deny the request, you have the right to have our denial reviewed by a licensed health care professional selected by **Atlanta Psychiatric Specialists** who did not participate in the initial decision.

Please contact the Records Custodian or Business Manager if you have additional questions or need further assistance.