ADVANTAGE BEHAVIORAL HEALTH

AUTHORIZATION for RELEASE of Protected Health Information

Legal: ALL ENTRIES MUST BE COMPLETED IN ORDER FOR THIS AUTHORIZATION TO BE EFFECTIVE***

This form shall NOT be altered, amended, or modified from its original form without express written consent from Advantage

			XXXX – XX -
Name of Client	Date of	Birth	Social Security Number (last 4)
	ANTAGE BEHAVIORAL HE :: 706-389-6789 Email: medic		Street, Athens, GA 30601 ns.org FAX #: 706-389-6775
TO:Release information to	Obtain information from _	Talk face to face with	Have phone contact with
THE FOLLOWING:	***************************************		
	(Individual/Agency/Ph	ysician/Attorney/Other)	
-	(Street Address)	, , , , , , , , , , , , , , , , , , , ,	
-	(City, State, Zip Code)	(*FAX	number or Email address)
For the Purpose of: Healthcare	Legal Other:		
Disclose the following material	: From Date	e(s) of Treatment:	THING THE STATE OF
Diagnosis	Initial Evaluation In	dividual Service Plan	Progress Notes
Medication(s)	Discharge Summary	Other:	- Ar WANNAM AND
disclosed without my written cons 5. I may inspect or obtain a copy of 6. I may refuse to sign this authoriz: 7. I get a copy of this form after I sig 8. I may revoke this authorization in 9. The revocation will not apply to ir 10. If I have any questions about the I understand that this form authorize the records. I understand in the alth records. I understand in the alth records. I authorize the recordination I authorization I	ries with it the potential for an unaut cohol and drug abuse records that I sent. the information described on this fo ation. In it, writing at any time and present my formation that has already been religiously been religiously been religiously been religiously been that a limit of the protected health in the protected of the protected health information concerning treatmeters of my protected health information concerning treatmeters of my protected health information between the protected health clinician(s) the protected in the disclosure of the protected will expire one (1) year from the disclosure one (1)	authorize to be disclosed rm if I request it, unless of written revocation to Advaeased in response to this iformation, I can contact the ords including psychicalow to authorize the and/or treatment informent and testing for HIV/Aution to the Court. To testify about my treatment inform my treatment record.	antage. authorization. he ABH Privacy Officer. latric, psychological, or other mental release of any of the following: hation. AIDS or other statutorily-protected disease. ent in legal proceedings/Court. ated. If I fail to specify an alternate
Signature of Client or Legal Repres	entative Relationship to client		Date of Signature
Signature of Witness	***************************************	***************************************	Date of Signature
For REVOCATION ONLY-			
This Authorization REVOKED on (sign and date).		
riseriorizzatori tika ottabo ott (.		Legal Representative)	(Date of Signature)