ADVANTAGE
BEHAVIORAL HEALTH SYSTEMS

ADVANTAGE BEHAVIORAL HEALTH SYSTEMS
Authorization for Release of Protected Health Information

"Legal - ALL ENTRIES MUST BE COMPLETED IN ORDER FOR THIS AUTHORIZATTON TO BE EFFECTIVE"
This form shall NOT be altered, amended, or modified from its original form without express written consent from Advantage.

______________________	______________________	X X X - X X - ______
Name of Client	Date of Birth	Social Security Number (Last 4)

I Hereby Authorize: ADVANTAGE BEHAVIORAL HEALTH - 250 Bray Street, Athens, GA 30601

TO: ____Release Information To ____Obtain Information From ____Talk Face to Face With ____Have Phone Contact With

THE FOLLOWING: ______________________________________
(Individual/Agency/Physician/Attorney/Other)

____
(Street Address City, State, Zip Code *required)

____
(*FAX number or Email address)

FOR THE PURPOSE OF: ____ Healthcare ____ Legal ____ Other: ______________________

DISCLOSE THE FOLLOWING MATERIAL: From Date(s) of Treatment: ______________________

____ Diagnosis ____ Initial Evaluation ____ Individual Service Plan ____ Progress Notes

____ Medication(s) ____ Discharge Summary ____ Other:

I UNDERSTAND THAT:

1. I am not required to sign this authorization in order to receive treatment, and it will not affect my payment status.
2. Disclosure of health information is voluntary.
3. Any disclosure of information carries with it the potential for an unauthorized re-disclosure.
4. Per federal law (42 CFR 2.32), alcohol and drug abuse records that I authorize to be disclosed per this document may not be further re-disclosed without my written consent.
5. I may inspect or obtain a copy of the information described on this form if I request it, unless otherwise prohibited by law.
6. I may refuse to sign this authorization.
7. I get a copy of this form after I sign it.
8. I may revoke this authorization in writing at any time and present my written revocation to Advantage.
9. The revocation will not apply to information that has already been released in response to this authorization
10. If I have any questions about the disclosure of my protected health information, I can contact the ABH Privacy Officer.

I UNDERSTAND THAT THIS FORM AUTHORIZES THE RELEASE OF MEDICAL RECORDS INCLUDING PSYCHIATRIC, PSYCHOLOGICAL, OR OTHER MENTAL HEALTH RECORDS. I UNDERSTAND THAT I MUST ENTER MY INITIALS BELOW TO AUTHORIZE THE RELEASE OF ANY OF THE FOLLOWING:

(Initial)* _____ I authorize the release of drug or alcohol diagnosis and/or treatment information.
(Initial)* _____ I authorize release of information concerning treatment and testing for HIV/AIDS or other statutorily-protected disease.
(Initial)* _____ I authorize the release of my protected health information to the Court.
(Initial)* _____ I authorize Advantage Behavioral Health clinician(s) to testify about my treatment in Legal Proceedings/Court.
(Initial)* _____ I authorize the release of Individual Therapy notes from my treatment record.

I HAVE READ THE ABOVE AND AUTHORIZE THE DISCLOSURE OF THE PROTECTED HEALTH INFORMATION AS STATED. IF I FAIL TO SPECIFY AN ALTERNATE EXPIRATION DATE, THIS AUTHORIZATION WILL EXPIRE ONE (1) YEAR FROM THE DATE OF SIGNATURE.
Alternate Expiration Date: ______________________

______________________	______________________	______________________
Signature of Client or Legal Representative	Relationship to Client	Date of Signature
Signature of Witness		Date of Signature

FOR REVOCATION ONLY

This Authorization REVOKED on (sign and date): ______________________ ______________
(Signature of Client/Legal Representative) Date of Signature