Richard Born PhD LLC
One Huntington Rd. #205 Tel: 706.543.7605
Athens, Georgia 30606 Fax: 706.543.2397
email: appliedpsych@bellsouth.net

Authorization for Use and Disclosure of Protected Health Information

Patient's Name: _____ Date of Birth _____

I hereby authorize

_____
_____
_____
(Name of provider or Healthcare Organization)

To disclose the Protected Health Information indicated below to:

_____
_____
_____
(Name of provider or Heathcare Organization)

For the purpose of:

_____
_____
_____

This authorization refers to the disclosure of the below specified information:

- Psychological Evaluation
- Treatment Summary
- Diagnoses
- Full Treatment Record (ie session notes)
- Other _____

Dates of Care: covered in this authorization: _____

1. I understand that I may inspect or obtain a copy of the protected health information described by this authorization.
2. I understand that the releasing entity will not condition treatment, payment, enrollment in a health plan or eligibility for benefits on my authorization for disclosure.
3. I understand that I may refuse to sign this authorization
4. I understand that I may revoke this authorization at any time by delivering written revocation to the Privacy Officer at the releasing entity above, not withstanding of information that was released prior to my revocation.

This authorization will expire on: _____

COPY PROVIDED: The releasing entity shall provide a copy of this signed authorization to you upon request. This information will be disclosed to you from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains.

Georgia state law requires an individual or the individual legal representative to give specific consent for the release of protected health information related to certain disease conditions. By my signature below I authorize release of the following medical information that may be held by the releasing entity: Information pertaining to my HIV status, records of mental health care and treatment, records of abuse, records of care and treatment for sexual transmitted disease, and records of substance abuse care and treatment

_____ _____
Signature of individual patient or representative authority Date