



AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Print Client First and Last Name _____ Previous Name(s), if Applicable _____ Client Date of Birth _____

RELEASE FROM: Healing Psychotherapy Practices of Georgia, LLC | 1301 Shiloh Road, suite 710,
Kennesaw, GA 30144 | tel: 770-792-0079 | fax: 1-888-394-1986 | info@healingpsychotherapyga.com

TO:

Name _____
Address _____
City, State, Zip _____
Phone _____
Fax _____

INFORMATION TO BE RELEASED			PURPOSE OF DISCLOSURE
Psychological / Psychiatric Evaluations / Neurological Workup	Yes	No	Continued Care
Treatment Plans and Progress Notes including current medications	Yes	No	Self
School Records	Yes	No	Specialist
Verbal Communication	Yes	No	PCP Communication and Care Coordination
Other (specify): _____	Yes	No	Permission to Provide Services at School
Discharge Summary	Yes	No	Disability Claim
			Other (specify): _____

Treatment Dates Requested: From _____ to _____
MM-DD-YY MM-DD-YY

I understand that this information will not be disclosed to any other agency or individual without my written authorization, except as allowed by law. I also understand that my protected health information, which is disclosed with this release, may be subject to redisclosure by the recipient and no longer protected by law. HPPGA is not responsible for any alterations made on its medical record copies, which have been released to any party. I understand that I have a right to a copy of this authorization after I sign it. I understand that HPPGA will not condition treatment on the completion of the authorization. A faxed



authorization is as valid as the original. The authorization automatically expires 12 months from the date it was signed or when services are terminated. I understand I can revoke this authorization at any time by sending written notice to HPPGA Privacy Official at 1301 Shiloh Road, suite 710, Kennesaw, GA 30144, except for disclosures already made based upon my original permission.

This authorization is given freely, voluntarily and without coercion.

Parental Signature Required for Clients 17 Years and Younger.

Requests are processed in the order received and within 7-10 business days.

Signature of Client or Client Guardian

Date