931 Monroe Dr. NE Suite A-102 423 ❖ Atlanta, Georgia 30308 ❖ Phone: (404) 585-0867

Authorization for Use or Disclosure of Protected Health Information

Client Information

Client: Last Name: _____ First Name: _____ DOB: _____/_____/_____

Guardian (if minor): Last Name: _____ First Name: _____

I authorize designated staff at The Wives Inc., to disclose/use/receive the following information about me: (Note: Request for release of psychotherapy notes cannot be combined with any other type of request.)

☐ My entire mental health record ☐ Therapy Notes ☐ Treatment Report ☐ Psychological Report
☐ Phone Conversation on all topics
☐ Only those pertaining to: _____
(Specific provider name and/or dates of treatment)

The facility's designated staff may disclose to/receive from:

_____
(Name of person, organization, or facility)

Purpose of Information Release:

☐ Further mental health care ☐ Payment of insurance claim ☐ Legal investigation
☐ Applying for insurance ☐ Vocational rehab, evaluation ☐ Disability determination
☐ At the request of the individual ☐ Other (specify): _____

Authorization and Signature

I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization if voluntary, that the information to be disclosed is protected by law, it will remain active for one year, and the use/disclosure is to be made to conform to my directions. The information that is used is and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

You have the right to revoke this authorization. To revoke this authorization, you must deliver a written statement, signed by you, to the organization or facility where you gave your authorization (identified above), which provides the date and purpose of this authorization and your intent to revoke it. Your revocation will be effective the date it is received by the organization/facility, except to the extent that the organization/facility has already relied upon your authorization to use or disclose your health information as described in the Notice of Privacy Practices.

_____ _____
Signature of Client Date

If signed by a guardian or personal representative:

a) Print your name: Last: _____First: _____

b) Indicate your relationship to the client and/or reason and legal authority for signing:
Patient is: ☐ minor ☐ incompetent ☐ disabled ☐ deceased
Legal authority: ☐ parent ☐ legal guardian ☐ representative of deceased