Psychology Clinic – 706-542-1173
139 Psychology Building, University of Georgia, Athens, GA 30602-3013

Request/Authorization for Disclosure of Protected Health Information

I hereby authorize (*name of individual(s)/organization providing information and/or records*):

Name/Organization _____ Phone _____

Address _____City _____State _____ Zip Code _____

to disclose the following information and/or records regarding (*name of client*):

Name _____ Phone _____

Birthdate _____ Social Security # _____

Address _____City _____State _____ Zip Code _____

The following information may be disclosed:
_____ Results of testing _____Intake and discharge summaries _____Educational records
_____ Treatment summaries _____ Neuropsychological/psychological evaluations _____Medications

Other (please explain; psychotherapy record excluded) _____

The purpose(s) of the disclosure is:
☐ At the request of individual ☐ Other _____

This information and/or records are to be disclosed only to (*name of individual(s)/organization receiving information and/or records*):

Name(s)/Organization _____ Phone _____ Fax _____

Address _____City _____State _____ Zip Code _____

The method(s) of this disclosure will be:
☐ I will pick up the copies myself (please allow 2 weeks to process and bring picture ID)
☐ Please mail the copies to the address listed above.
☐ Please fax the copies to the number listed above.
☐ Please disclose information listed above by phone with individual/organization listed above.

By signing below, I acknowledge that I have read and understand this document and that I have voluntarily given my authorization to disclose the information and/or records selected to the individual(s) and/or organization that I named for the purpose(s) and by the method(s) that I checked. I further understand that I may revoke this Authorization, except if this it was obtained as a condition of obtaining insurance coverage, at any time by providing a written notice to the Psychology Clinic. The revocation shall be effective except to the extent that the Psychology Clinic has already used or disclosed information in reliance on this Authorization. I understand that my information may be redisclosed by the authorized person(s)/organization receiving the information, and at that point, the information may no longer be protected under the terms of this agreement. **Please refer to *Notice of Health Information Privacy Practices* for more detailed information.** This consent will expire automatically after one year from the date on which it is signed, or upon fulfillment of the purposes stated above, unless otherwise stated.

Client signature: _____ Date: _____

Parent/representative signature: _____ Date: _____

Authority to act on behalf of client: _____

Processed by (*staff/therapist*): _____ Date copy given to patient _____