Southern Behavioral Healthcare, P.C.

110 Braxton Court
Fayetteville, GA 30214
770-461-6422 / 678-610-7100 (phone)
770-461-0498 / 678-610-7111 (fax)

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: ____ DOB: ___/___/_____
Last First MI

I hereby request and authorize: __Southern Behavioral Healthcare, P.C

To (Check All that Apply) **__Obtain From** **__Release To** **__Pick Up**

Name of Provider or Agency____
Mailing Address____
Telephone: ________________________ Fax: ___________________________

The following information from my records (Check All That Apply):

__Admission History and Physical __Psychiatric Evaluation
__Progress Notes __Lab/EKG/ Radiology Reports
__Entire Inpatient Records __Psychosocial Evaluation
__Consultations __Entire Outpatient Records
__All Records from Other Physicians __Medical Evaluations/Treatments __Other_______________________

For the following purposes (Check all that apply):
__At My Request __Continued Care __Other_______________________

**All information I hereby authorize to be obtained or released by the recipient with my written consent. This authorization shall expire 1 year from the date of signature below unless revoked prior to the date. I understand that I may withdraw my consent at any time except to the extent that action has been taken which was based on my consent.

____________________________________ Date:_____________
Signature of Patient

____________________________________ Date:_____________
Signature of Parent/Guardian if minor

____________________________________ Date:_____________
Signature of Witness

Prohibition of Redisclosure: This protected health information has been disclosed to you from records whose confidentiality is protected by federal law. Any further redisclosure is strictly prohibited without the specific written consent of the person whom it pertains. A general authorization for the release of medical or other information is not sufficient for this purpose.

Date of Release:_____________ Staff Initial_____