Villa Rica Behavioral Health, PC
Office: 770 456- 2788 Fax: 770 456-2790

Authorization to Disclose Protective Health Information

Patient's name: ____

Date of birth: ____

Current address: ____

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Home phone number: _____________________

Cell number: __________________________

I authorized the release of protective health information to be disclosed and used by the following:

To/from **___ Individual** **___ Other health care provider** **___ Other health care facility** **___Department of Family and Children's Services** **___Other: _____________________** **_____________________________**	**To/from** **Villa Rica Behavioral Health PC** **514 W Bankhead Highway** **Suite 400** **Villa Rica, Georgia 30180**

Name: ____

Address: ____

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____

Phone number: -------------------------------- Fax number: ____________________

Types of Information to be released:

___ Initial psychiatric evaluation

___ Psychiatric progress notes

___ Medication logs

____ Vital signs log

The purpose for the use/disclosure of this information illness:
____Continued medical care
____Patient/personal representative
____Physician care
____ Legal
____ Insurance
____ Other: ____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present a written revocation to Villa Rica Behavioral Health, PC. I understand that revocation will not apply to any information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise revoked, this expiration date, event or condition will expire on the following date:
Date of expiration: ______________________________________

> **I understand that authorizing this disclosure of this health information is voluntary. I can refuse to sign this authorization if I chose.. I need not sign this authorization in order to assure treatment. I understand that I may inspect or obtain a copy of this information for a designated fee as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure by another source and the information may not be protected by Federal confidentiality rules.**

Signature of patient, parent or guardian: __________________________________

Relationship to patient: ____