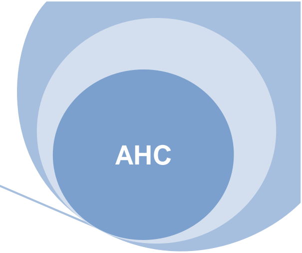

Atlanta Healing Center
Susan K. Blank M.D.
3985 Steve Reynolds Blvd. Bldg. P.
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Phone 770.696.9862 Fax 770.710.0243

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

Patient Name: ____ Birthdate: ________________
Street Address: ______________________________________City: __________________State: _________ Zip: _____
Phone: _____________________________ SS #: _XXX___ -- _XX_ -- ______

I AUTHORIZE Atlanta Healing Center TO RELEASE TO ❒ AND RECEIVE FROM ❒

Name/Organization: ____
Street Address: _____________________________________ City: _________________ State: _________ Zip______
Phone: ___________________________ Fax: ____________________________

THE ABOVE PERSON/AGENCY THE FOLLOWING INFORMATION: Check Y for Yes or N for No

___**Y** ___**N** History and Physical Exam
___**Y** ___**N** Family Assessment
___**Y** ___**N** Financial Information
___**Y** ___**N** Treatment Update / Status – Verbal
___**Y** ___**N** Treatment Update / Status – Written
___**Y** ___**N** Imaging Reports
___**Y** ___**N** Assessment Report
___**Y** ___**N** Progress Notes
___**Y** ___**N** Medication List
___**Y** ___**N** Laboratory Reports
___**Y** ___**N** Drug Screens
___**Y** ___**N** Psychiatric Consult/Evaluation
___**Y** ___**N** Discharge Summary
___**Y** ___**N** Other: (Specify): ____

FOR THE PURPOSE OF: ____

Dates to Release: ❒ All Dates of Treatment ❒ Specific Dates: From _________ to __________

In addition to verbal and written reports I agree this information may be released/exchanged via: ____ Electronic ____ Fax

Medical records frequently contain confidential remarks furnished by the patient, patient's family and staff. If, in the judgment of the medical staff, disclosure of such information will be harmful to the patient, release of such information will be withheld.

I understand that information received, or medical records prepared after this release form is completed, regarding my condition and the services I have received during my diagnosis and treatment, may be subject to release to authorized parties in compliance with federal and state law and the terms of this form. **I understand that the records released may contain alcohol and drug treatment, AIDS/HIV or psychiatric/psychological/psychosexual information.**

This consent for information is given freely, voluntarily and without coercion. I understand that I may revoke this consent to release information in writing at any time, except for information that has already been released under this valid consent. In any event, upon fulfillment of the above-stated purpose, this consent will automatically expire one year from the date signed. I further understand that Atlanta Healing Center reserves the right to notify the above-named person, corporation or agency of my revocation in the event that I revoke this consent to release information. This consent expires one year from date below.

___________________________/___________ ___________________________/___________
PATIENT SIGNATURE/DATE WITNESS SIGNATURE/ DATE

Renewal Date: ___________ ___________________________/___________ ___________________________/___________
PATIENT SIGNATURE/DATE WITNESS SIGNATURE/ DATE

Renewal Date: ___________ ___________________________/___________ ___________________________/___________
PATIENT SIGNATURE/DATE WITNESS SIGNATURE/ DATE

"This information has been disclosed to you from records whose confidentiality is protected by State: Section 5328, Welfare and Institutions Code; and/or Federal Law. Federal Regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose."

Revised 5/2018