

Atlanta Family COUNSELING

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CONSENT AND AUTHORIZATION TO RELEASE INFORMATION OR MEDICAL RECORDS UNDER THE PROTECTION OF FEDERAL LAW TITLE 42 CFR, CHAPTER 11, PART II.

NAME: _____ DOB _____

I, the above mentioned, authorize Atlanta Family Counseling Center, Inc. to release/obtain information to the facilities/persons listed below by mode of: Fax, Phone, Personal Conference, or Copies, that may be needed to treat me more effectively.

To: Facility/Person _____ Phone: _____

Address: _____

Date of Service: _____

Information to be sent:

- | | |
|---|---|
| <input type="checkbox"/> Results of psychological testing | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> MMPI profile | <input type="checkbox"/> Recommendation for current therapy |
| <input type="checkbox"/> Medication | <input type="checkbox"/> Domestic Violence Orientation |
| <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Anger Management Evaluation |
| <input type="checkbox"/> Statement of Progress | <input type="checkbox"/> Substance Abuse Evaluation |
| <input type="checkbox"/> School records | <input type="checkbox"/> Psychosocial Evaluation |
| <input type="checkbox"/> Other | |

To be used for the purpose of: _____

"This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulation (42, CRF, Part II) prohibit you from making any further disclosures of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation. A general authorization for the release of medical or other information is not sufficient for this purpose."

This authorization to release/receive information shall be effective for twelve months. You may terminate this authorization, however, at any time except to the extent that the program or person making the disclosure has already acted in reliance upon it.

I hereby release Atlanta Family Counseling Center, Inc. from all legal liability that might arise from the release of information requested. I consider a photocopy of this authorization to be as valid as the original.

Client _____ Date _____ Parent/Legal Guardian (relationship) _____ Date _____

Witness _____ Date _____