

Paraclete Counseling Center, Inc.  
3905 Johns Creek Court  
Suite 260  
Suwanee, GA 30024

## AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

1. I am completing this form to allow the use and sharing of protected health information about

Printed name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

2. I authorize this person or organization \_\_\_\_\_

3a. To use or disclose the following information:

- Inpatient or outpatient treatment records for physical and or psychological, psychiatric, or emotional illness or drug and/or alcohol abuse.
- Admission and discharge summaries
- Psychological or psychiatric evaluation(s), reports, assessments, treatment notes, summaries, or other documents with diagnoses, prognoses, recommendations, or testing records, and behavioral observations or check lists completed by any staff member or the patient, or similar documents.
- Treatment, recovery, rehabilitation, aftercare plans and other similar plans.
- Social, family, educational, and vocational histories
- Social work assessments and plans
- Progress, nursing, case or similar notes
- Evaluations and reports of consultants
- Information about how the patient's condition(s) affects or has affected his or her ability to work, and to complete tasks or activities of daily living
- Vocational evaluations and reports
- Billing records
- Academic and educational records, including achievement and other tests' results, reports of teachers' observations, and all other school or special education documents
- Complete copy of the medical record
- Other: \_\_\_\_\_

3b. Dates of care included: From \_\_\_\_\_ to \_\_\_\_\_

4. To this person or organization \_\_\_\_\_

5. The information will be used/disclosed for the following purposes:

\_\_\_\_\_

6. I understand and agree that this Authorization will be valid and in effect until \_\_\_\_\_ (date). I understand that after that date or event, no more of this information can be used or released to the person or organization unless I sign a new Authorization like this one.

7. I understand that I can revoke or cancel this authorization at any time by sending a letter to the Privacy Officer of the organization listed above and which is to supply this information. If I do this, it will prevent any releases after the date it is received but cannot change the fact that some information may have been sent or shared before that date.
8. I understand that I do not have to sign this authorization and that my refusal to Sign will not affect my abilities to obtain treatment from the professional or facility listed at number 4 above, nor will it affect my eligibility for benefits.
9. I understand that I may inspect and have a copy of the health information described in this authorization.
10. I understand that if the person or entity that receives the information is not a Health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations.
11. I understand that in some circumstances, this professional or facility will receive compensation for costs associated with the use or disclosure of my health information (such as copying fees).
12. I affirm that everything in this form that was not clear to me has been explained to me and I believe I now understand all of it.

\_\_\_\_\_  
Signature of client or his or her personal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of client or personal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of personal representative's authority

13. I, a mental health professional, have discussed the issues above with the client and/or his personal representative. My observations of his or her behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

\_\_\_\_\_  
Signature of professional

\_\_\_\_\_  
Printed name of professional

\_\_\_\_\_  
Date