AUTHORIZATION TO RELEASE MENTAL HEALTH INFORMATION

FROM YOUR CLINICAL RECORD TO THE PERSON/ORGANIZATION YOU DESIGNATE

I,____, DOB______________________________ authorize Affirmative Transformation Services, LLC to exchange information with:

Name/Organization:______________________________________Phone Number:_______________________________

Address:____Fax Number:_________________________________

Specific nature of information to be released:

_____any or all of the following
_____attendance/scheduling/transportation
_____information related to payment
_____presenting complaints/issues
_____diagnosis and/or assessment results
_____treatment plan and goals
_____summary of treatment
_____response to treatment/progress
_____prognosis
_____recommendations/suggestions
_____substance use/abuse information______initial
_____other:___________________________

The information above is being released for the purpose of:

_____facilitating consultation and/or collaboration
_____facilitating continuity of treatment
_____facilitating scheduling/transportation
_____Other: _____________________
_______facilitating payment
_______facilitating family involvement in treatment

I understand that:

1. This consent will automatically expire one year from signing unless a different date of expiration is specified here:___________________________________
2. I have the right to copy and inspect the information being disclosed.
3. I have the right to revoke this authorization, in writing, at any time by sending such written notification to my provider's office. However, my revocation will not be effective to the extent that my provider has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage, and the insurer has a legal right to contest a claim.
4. I understand that unless otherwise limited by state or federal regulation, and except to the extent that action has been taken based upon it, I may withdraw this authorization at any time by sending written notice of my withdrawal of this authorization to the staff of the healthcare provider who is providing services to me, OR to the Department's Privacy Officer at 2 Peachtree St. NW, Atlanta, GA 30303-3142.

____ ___________________
Client (Adult or Minor over age 12) Date

____ ___________________
Parent/Guardian of minor or legally disabled client/patient (if applicable) Date

____ ___________________
Witness Date

If the signature is not the client's, indicate the legal relationship of the signer to the client and the legal basis on which the consent is given for the client:
Notice to Receiving Agency/Facility/Person: Under Federal Act of July 1, 1975, Confidentiality of Alcohol and Drug Abuse Patient Records, no such records, nor information from such records, may be further disclosed without the client's specific authorization for such disclosure.