Better Mood Clinic of South Georgia, LLC

2935 N. Ashley St., Building F
Valdosta, GA 31602
Phone: (229) 333 - 2273
Fax: (229) 506 - 5403

Authorization request to RELEASE and/or RECEIVE protected health information

Please print the following information:

Patient (legal name): _____ Patient phone: _____

Address: _____ Date of Birth: _____

_____ SSN: _____-_____-_____

I authorize the Better Mood Clinic of South Georgia (BMC of SGA) and/or staff to use or disclose my (the patient's) individually identifiable **protected health information (PHI**). I understand that the information disclosed after this authorization may no longer be protected by federal or state law if there is a concern for my safety or the safety of another individual. Such safety issues that impose a duty to report by law include child abuse or child/elderly neglect, and/or the presentation of a threat to life/safety of the patient or another individual.

BMC of SGA will not condition my treatment on whether I provide authorization of the requested use or disclosure except (1) if my treatment is related to research, or (2) healthcare services are provided to me solely for the purpose of creating PHI for the disclosure to a third party.

Information to be Used or Disclosed: Please specify in the blanks below to whom and/or where you would like to release the patients' psychotherapy notes to. Your ECR at the BMC of SGA contains **medical notes** (notes summarizing the care you received from a psychiatrist, family practice provider or a nurse practitioner), **medication notes** (notes listing your medication history), miscellaneous **clinical notes** (notes documenting phone calls, appointments scheduled and appointment history) and psychotherapy notes. **Psychotherapy notes** are defined as ***notes recorded in any medium by a health care provider who is a mental health professional, documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session that are maintained separately from one's medical records.*** The Privacy Rule provides a higher level of protection for psychotherapy notes than for other protected health care information.

I authorize the request to release and/or receive all of the patient's **Psychotherapy notes**, as defined above in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA Privacy Rule") and as outlined in 45 C.F.R. § 164.501***, to or from*** the following:

(Name)_____ (Address) _____

(Fax)_____ _____

This release covers the above entity's agents, employees, experts, and consultants.

Reason for release and/or receive: ☐ request of the patient/guardian
☐ other (examples: doctor, lawyer, etc.) _____

Person (s) Authorized to Make the Use or Disclosure:
I hereby authorize the healthcare provider to include any psychiatrist, psychologist, mental health professional, physician, pharmacist, or other healthcare practitioner who maintains the patient's PHI to release and/or receive the patient's PHI as specified in this authorization.

Check *each box* next to the statements as you read them indicating your understanding.

- ☐ I understand this authorization is voluntary, and the provider cannot condition the patient's treatment on whether or not I sign this authorization.
- ☐ I understand this authorization is binding until revoked by ***written notice*** to the provider.
- ☐ I understand that I may revoke this authorization at any time by notifying the BMC of SGA ***in writing*** at the following address: 2935 N. Ashley St. Bldg F, Valdosta, GA 31602.
- ☐ However, if I choose to revoke this authorization, it will not have any effect on any actions taken **before** the receipt of my revoking this authorization.
- ☐ I understand PHI used or disclosed after this authorization may be subject to disclosure by the recipient of this authorization, in which case the PHI might not be protected under the HIPAA Privacy Rule under the conditions specified above in the first paragraph of page one.
- ☐ ***Under Workman's Compensation***, I understand the PHI will be released to the workers compensation carrier and are not covered under HIPAA.
- ☐ I give permission for the BMC of SGA to disclose any medical, HIV, psychiatric and/or substance abuse information contained in the patient's PHI.
- ☐ I hereby release _____, his/her/its affiliates, agents, employees, medical staff, officers and directors from any liability, damages and expenses arising in connection with the use or disclosure of the patient's PHI following this authorization.
- ☐ I understand my rights to file a complaint in writing if I believe BMC of SGA has violated my privacy rights. Complaints may be filed with BMC of SGA's Privacy Officer, John Lovette or with the Secretary of Health and Human Services @ 200 Independence Ave. SW, Washington D.C. 20201 or by calling (202) 619-0257. We will not retaliate against you for filing a complaint.
- ☐ I understand that this authorization will **expire 12 months** from the date signed below.
- ☐ I request the PHI to be released be sent in the following format:
  - ○ Paper (a fee of $1.00 will be charged for each page of PHI)
  - ○ Fax transmittal (a fee of $1.00 will be charged for each page of PHI)
  - ○ Electronic transmittal of records (minimal fee of $25; final fee will be dependent on the amount of time spent in retrieval)

_____ _____
Patient Signature Date

_____ _____
Name of Patient's Personal Representative Signature of Personal Representative

List the basis of the Personal Representative's authority to sign for the patient:

_____

(Are you are the parent of a minor patient or the legal guardian of an adult or minor patient.)

_____ _____
Witness Date

[Note: A copy of the signed authorization must be provided to the patient or their representative]