DOTHAN BEHAVIORAL MEDICINE CLINIC

408 Healthwest Drive Dothan AL 36303
101 Medical Drive Dothan AL 36303
(Office) 334-702-7222 (Fax) 334-712-0972
(Fax) 334-702-1944

Authorization For The Release of Information

This information is confidential and privileged, for the professional use only, not for publication, and to be used only in the patient's interest.

Patients Name: ______________________________ Date of Birth: ____________

Address: ____

I hereby authorize Dothan Behavioral Medicine Clinic at 408 Healthwest Drive / 101 Medical Drive Dothan Al 36303
( ) To Release to ( ) To Receive From ( ) To Exchange with

Name of Person or Agency: ____________________________________

Address: ______________________________ Phone: ______________

______________________________ Fax: ______________

The following information:

__ Initial Evaluation
__ Laboratory Results
__ Medication Records
__ Dates of treatment
__ Psychiatric Records
__ Other (specify) ______________________________

__ Consultation Reports
__ Psychosocial Assessment
__ Treatment Plan/Goals
__ Psychological Testing

__ Progress Notes
__ EKG/EEG Reports
__ Diagnosis
__ Drug Assessment

I understand that I may revoke this consent at any time by giving written notice to Dothan Behavioral Medicine to the extent that the action has been taken in response to this authorization. If prior notice of revocation is received, this consent will expire automatically one year from the date authorization is given. I understand that the confidentiality of this information is protected by Federal and State law(s) and cannot be released without my written consent.

This authorization and request is fully understood and is made voluntarily on my part on: ______________
(Date)

____
Patient signature (if 14 years or older)

____
Parent/ Legal Guardian signature
(*Relationship to Patient: ______________)

I attest to the identity of the above signature(s): ______________________ Date: __________
(Witness Signature)

This information is disclosed from patient records protected by Federal Confidentiality Regulations (42CFR Part 2). The Federal regulations prohibit you from making any further disclose of this information further release is expressly permitted by the written consent of the person to whom it pertains or as otherwise written permitted by 42 CFR Part 2. A general authorization for the release of medical or other patient identifying or subpoena is NOT sufficient for this purpose.

Any information released or received as a result of this consent shall not be further relayed in any way to any person, organization, and entity or without an additional written consent from me. I may withdraw this consent by giving written notification to the above party, at any time prior to the disclosure or release of information. In the absence of my prior withdrawal, this consent will expire 360 days after it is signed.

I have read this notice and consent to prior signing and I understand its content. Date: __________

____
Patient signature (if 14 years or older)

____
Parent/Legal Guardian signature
(*Relationship to Patient: ____________)

Witness: ______________________ Date: ______________

For Office Use Only:

Faxed: _____ Mailed: ______ Picked Up: _____ Keep on File: _____ Date: ______ Initials: ________

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION ONE IT HAS BEEN SIGNED