Dothan Behavioral Medicine Clinic
408 Healthwest Drive, Dothan, AL 36303
Phone: (334) 702-7222 Fax: (334) 699-5790

AUTHORIZATION FOR THE RELEASE OF INFORMATION

This information is confidential and privileged, for professional use only, not for publication, and is to be used only in the patient's interest. The purpose for disclosure is to provide continuity of treatment.

PATIENT'S NAME: _____ **DATE OF BIRTH:** _____

ADDRESS: _____
(Street) (City) (State) (Zip Code)

I HEREBY AUTHORIZE: Dothan Behavioral Medicine Clinic/408 Healthwest Drive, Dothan, AL 36303
( ) to release to ( ) to receive from ( ) or exchange with:

Name of Person or Agency: _____
Address: _____
_____

THE FOLLOWING INFORMATION:

[ ] Initial Evaluation	**[ ] Consultation Report(s)**	**[ ] Progress Notes/Reports**
[ ] Dates of Treatment	**[ ] Psychosocial Assessment**	**[ ] EKG/EEG Reports**
[ ] Laboratory Results	**[ ] Treatment Plan/Goals**	**[ ] Diagnosis**
[ ] Medication Records	**[ ] Psychological Testing**	**[ ] Drug Assessment(s)**

[ ] Other (specify): _____
_____

I understand that I may revoke this consent at any time by giving written notice to Dothan Behavioral Medicine Clinic to the extent that action has been taken in response to this authorization. If no prior notice of revocation is received, this consent will expire automatically one (1) year from the date in which this 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 consent.

This authorization and request is fully understood and is made voluntarily on my part on: _____
Month/Day/Year

_____ _____
Patient Signature **(14 years or older)** Parent/Legal Guardian Signature

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

This information is disclosed from patient records protected by Federal Confidentiality Regulations (42 CFR Part 2). The federal regulations prohibit you from making any further disclosure of this information unless further release is expressly permitted by the written consent of the person 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 information 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 other person, organization, entity, or other without 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 prior to signing and understand the contents.

Signed: _____ _____ _____
Patient Signature **(14 years or older)** Parent/Legal Guardian Signature Date

Witness: _____ Date: _____

( ) Faxed ( ) Mailed ( ) Pick-Up Date: _____ Initials: _____

You are entitled to a copy of the information after you sign it.