

Authorization to Release Protected Health Information (PHI)

This authorization allows the DeKalb Community Service Board to provide/receive information relating to my medical record.

Medical Records and Release Department
445 Winn Way 4th Floor
Decatur, GA 30030
Phone: 404-508-7714 Fax: 404-508-7715

(Select One Location):

- Clifton Springs Mental Health
- Kirkwood Mental Health
- North DeKalb Mental Health
- Winn Way Mental Health
- Crisis Center
- DeKalb Addiction Clinic
- PSR
- Peer Support
- Drug Court
- Jail Diversion
- DD Day Program
- Residential Services (MH/SA)
- DEC

Has my permission to:

- Share Information with:** (this means verbal sharing only)
- Release (send) information to:** (this means we will send your record)
- Receive (get) information from:** (this means we will have your record sent to the DCSB)

Name: _____
Address: _____
City: _____
State: _____ Zip: _____
Phone: _____ Fax: _____

Relationship to Consumer: _____ Email Address: _____

Information to be released/shared:

<input type="checkbox"/> Clinical Assessment	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> History and Physical Exam
<input type="checkbox"/> Lab Reports	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Drug Screen Results
<input type="checkbox"/> Physician Orders	<input type="checkbox"/> Psychiatric Assessment	<input type="checkbox"/> Treatment Plan
<input type="checkbox"/> Other (Specify): _____		<input type="checkbox"/> Physicians Service Note

Reason for release/sharing:

<input type="checkbox"/> Continued care by another provider	<input type="checkbox"/> Insurance Purposes	<input type="checkbox"/> Disability/Attorney
<input type="checkbox"/> Family Involvement	<input type="checkbox"/> Personal Use	
<input type="checkbox"/> Other (specify): _____		

If the consumer is ACTIVELY receiving treatment, and 'RELEASE' is checked, the physician MUST sign to authorize the release for 'Family Involvement' or 'Personal Use'.

Physician Signature: _____

I have read and understand the following information regarding this request:

- The recipient of this information is prohibited under federal and state laws from making any further disclosure of this information unless written consent of the consumer is issued, or as otherwise permitted by laws governing the confidentiality of records (42 CFR, part 2)
- Once the records are released, the DeKalb CSB cannot guarantee that the recipient of this information will not re-disclose the information to a third party.
- The DeKalb CSB does NOT re-release information received from a third party, regardless of the request made.
- There may be a fee for releasing these records, charged to the recipient of the records.
- If I do not sign this form, I will still be treated.
- I understand that the information in my record may include information relating to sexually transmitted diseases such as AIDS or HIV, and may include information relating to mental health treatment, and/or treatment for substance abuse.
- This authorization expires 1 year after being signed, or sooner, if a date is entered here: _____
- If I change my mind, or want to revoke this authorization, I can sign and date here: _____
- To be valid, this form must be filled out completely, signed and witnessed. A facsimile (fax) or scanned copy is valid as the original, if it has not been altered.**

Signature of person or authorized person

Authorized person's relationship

Date

If consumer is unable to sign, please indicate why: Minor Deceased Other (Specify): _____

Witness name (Printed)

Witness Signature

Date



Authorization to release or share Protected Health Information (PHI)

DCSB Form 630

Rev. 5/12/2016

Consumer Name (Last, First): _____
Consumer Acct Number: _____
Consumer Date of Birth: _____
Consumer Phone Number: _____

