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 **Email:** medicalrecords@dekcsb.org

(Select Location(s) and/or Program):
- ☐ Clifton Springs
- ☐ Kirkwood
- ☐ North DeKalb
- ☐ Winn Way
- ☐ DRCC (Crisis Center)
- ☐ DeKalb Addiction Clinic (DAC)
- ☐ East DeKalb
- ☐ ORSAT
- ☐ Service Center
- ☐ DD Residential
- ☐ BH Residential
- ☐ Jail in-Reach Program
- ☐ Co-Responder Program
- ☐ APEX

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 Client: _____ Email Address _____

Information to be released/shared:

- ☐ Clinical Assessment
- ☐ Discharge Summary
- ☐ History and Physical Exam
- ☐ Lab Reports
- ☐ Progress Notes
- ☐ Drug Screen Results
- ☐ Treatment Letter
- ☐ Psychiatric Assessment
- ☐ Treatment Plan
- ☐ Diagnosis
- ☐ Physician Service Note
- ☐ Other (Specify): _____

Reason for release/sharing:

- ☐ Continued care by another provider
- ☐ Insurance Purposes
- ☐ Disability/Attorney
- ☐ Family Involvement
- ☐ Personal Use
- ☐ Other (specify): _____

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

Physician Signature: _____

Time period requested for medical records: from _____ to _____

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 Client 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 Client is unable to sign, please indicate why: ☐ Minor ☐ Deceased ☐ Other (Specify):

_____ Witness name (Printed)

_____ Witness Signature

_____ Date

DeKalb CSB **Authorization to release or share Protected Health Information (PHI)**

DCSB Form 630 **Rev. 8/1/2023**

Client Name (Last, First): _____

Client Acct Number: _____

Client Date of Birth: _____

Client Phone Number: _____