

Authorization to Release Information

Section A: Use or Disclosure of Health Information

By signing this form, I authorize the use and/or disclosure of my (and/or my dependent[s]) individually identifiable health information maintained by: (Please fill in information about person who has your records.)

Name: _____

Address: _____

Relationship: _____ Phone Number (s): _____

My (and/or my dependent[s]) health information may be disclosed to and from:

Name: Anne Danner, LPC

Address: 2944 Blackwood Road, Decatur, Georgia 30033

Section B: Scope and Use of Disclosure

Information that may be used or disclosed based on this authorization is as follows (check one):

- All health information about me (and/or my dependent[s]), including my medical records created or received by the provider. This information may include, if applicable:
- Information pertaining to the identity, diagnosis, prognosis or treatment for alcohol or drug abuse
 - Information concerning the testing for HIV (Human Immune Virus) and/or treatment for AIDS (Acquired Immune Deficiency Syndrome) and any related conditions
 - Privileged communications between me (and/or my dependent[s]) and a behavioral health or other health professional or between them concerning my (and/or my dependent[s]) communications with any of them

All health information about me (and/or my dependent[s]) as described in the preceding checkbox, **excluding** the following: _____

Specific health information **including only** the following: _____

Section C: Purpose of Use or Disclosure

The purpose for this disclosure is (check one):

Specifically, the following: **Continuity of treatment**

The consumer chooses not to disclose the purpose. NOTE: This box may NOT be checked if the information to be disclosed pertains to alcohol or drug abuse information.

Section D: Expiration NOTE: If an expiration event is used, the event must relate to the consumer or the purpose for the disclosure.

Date (mm/dd/yyyy) or Event: _____

Section E: Other Important Information

A copy of this authorization is available to me, or to my authorized representative, upon request and will serve as the original.

I understand that if this information is to be received by individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by federal privacy regulations, my information provided in this document may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations. I have the right to revoke this release of information/authorization at any time, except to the extent that the person/company has already taken action on the disclosure provisions contained in this document. If I choose to revoke the release of information/authorization, I must notify the person/company identified in Section A **in writing** that I request termination of this release of information/authorization.

Signature of Consumer _____ Date _____

Anne Danner _____
Signature of Witness _____ Date May 7, 2008

Signature of Parent (if applicable) _____ Date _____