AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

INSTRUCTIONS:
This form must be completed in its entirety. Each section must be completed, or this form could be returned as invalid.

<table>
<tr><td rowspan="6">Please Print Client Information</td><td colspan="3">Full Name | Maiden Name (if applicable)</td></tr>
<tr><td>Date of Birth</td><td colspan="2">SSN</td></tr>
<tr><td colspan="3">Address</td></tr>
<tr><td>City</td><td>State</td><td>Zip</td></tr>
<tr><td colspan="3">Phone</td></tr>
<tr><td colspan="3">Email</td></tr>
<tr><td rowspan="7">WHERE do you want us to send or obtain your information from?</td><td colspan="3">I hereby authorize Gateway Community Service Board to take the following action:
☐ RELEASE my medical records to: ☐ OBTAIN my medical records from:</td></tr>
<tr><td colspan="3">Individual/Organization</td></tr>
<tr><td colspan="3">Address</td></tr>
<tr><td>City</td><td>State</td><td>Zip</td></tr>
<tr><td>Phone</td><td colspan="2">Fax</td></tr>
<tr><td colspan="3">Email</td></tr>
<tr><td colspan="3">Release Method ☐ Mail ☐ Fax ☐ Secure Email</td></tr>
<tr><td>Information to be released:

WHAT do you want shared or obtained?

Check all the appropriate boxes.</td><td colspan="3">Service Date(s) Being Requested: From ____/____/____ To ____/____/_____

Check off the information you would like to be sent/obtained:
☐ All records ☐ Initial Psychiatric Evaluation ☐ Nursing Assessment
☐ Behavioral Health Assessment ☐ Medication List ☐ Lab Results
☐ Drug Screens ☐ Clinical Progress Notes ☐ Follow-up Notes
☐ Nursing Notes ☐ Discharge Summary ☐ Treatment/Safety Plan
☐ Other, specify: ____</td></tr>
<tr><td>Purpose of Release

WHY is it needed?</td><td colspan="3">☐ Continuity of Care ☐ Personal Use ☐ SSDI/SSI ☐ Insurance
☐ Legal ☐ Case Management ☐ Probation

☐ Other, specify: ____</td></tr>
</table>

EXPIRATION OF AUTHORIZATION
Unless I request in writing otherwise, I understand that this authorization will expire on ________________________ *(Insert expiration date or event)*. If I do not specify an expiration date or event, this authorization will expire twenty-four (24) months from the date on which I signed this authorization.

RIGHT TO REVOKE
I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department of Gateway Community Service Board. I understand that this revocation will not apply to any health information that has already been released in response to this authorization.

RE-DISCLOSURE
I understand that if my health information is disclosed to a party other than a health care provider, health plan, or health care clearinghouse subject to federal privacy regulations, the health information may no longer be protected by the federal privacy regulations.

FEES
I understand that federal and state laws allow a fee to be charged for the copying of records and I will be responsible for the payment of such fees, if applicable.

WAIVER
If the health information I have requested Gateway Community Service Board to disclose contains any information related to certain infectious diseases (including but not limited to, HIV/AIDS confidential information) or substance use, I consent to the disclose of such information by Gateway Community Service Board and waive any privileges or confidentiality with regard to such disclosures for the purpose(s) of releasing it to the party or parties authorized on this authorization.

IMPORTANT NOTICE
When the client is a minor or is not mentally competent to give consent, the signature of an authorized parent, guardian, or other legal representative is required. **(Proof of authority to make healthcare decisions on behalf of the client must be submitted with this form, if applicable)**

________________________________ ________________________
Client Signature (or Legal Representative) Date

________________________________ ________________________
Printed Name Relationship to Client

SUBMIT COMPLETED FORM TO: **ATTN: MEDICAL RECORDS DEPARTMENT**
View Point Health
PO BOX 687
Lawrenceville, GA 30046

IN-PERSON:	**FAX:**	**EMAIL:**
Your Outpatient Center	678-212-6395	GATEWAYRECORDS@VPHEALTH.ORG