Chip Abernathy, LPC
6100 Lake Forrest DR, Suite 450, Atlanta, GA 30328 Phone (770) 862-7585

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Patient Name: _____

Birth Date: _____ Social Security Number: _____

I HEREBY REQUEST AND AUTHORIZE CHIP ABERNATHY, LPC:

CHECK ALL THAT APPLY: [ ] TO RELEASE TO (Charges May Apply) [ ] TO REQUEST FROM

_____
(Name)

_____
(Address) (City/State)

(Email) _____ (PHONE) _____

(FAX) _____

THE FOLLOWING INFORMATIO
CHECK APPROPRIATE AREAS TO BE RELEASED – YOU MUST BE SPECIFIC

[ ] PATIENT INFORMATION FORM
[ ] INFORMED CONSENT FORM
[ ] TELEPHONE CALLS/VERBAL COMMUNICATION
[ ] CLINICAL ASSESSMENT (DATA BASE)
[ ] LETTER RE: PROGRESS/RECOMMENDATIONS
[ ] REPORT TO PROBATION OFFICER/COURT
[ ] PROGRESS NOTES
[ ] TREATMENT PLAN
[ ] CONSULTATIONS
[ ] CONTINUING CARE PLAN
[ ] OTHER (PLEASE SPECIFY): _____

FOR THE PURPOSE OF: (MUST BE COMPLETED) ( ) CONTINUED TREATMENT
( ) OTHER_____

I AGREE TO INDEMNIFY AND HOLD HARMLESS CHIP ABERNATHY AND STAFF/DESIGNEES FROM ALL LIABILITY THAT MAY ARISE FROM THE RELEASE OF THE INFORMATION HEREIN REQUESTED.

MEDICAL RECORDS FREQUENTLY CONTAIN INFORMATION THAT MAY BE PRIVILEGED AND/OR CONFIDENTIAL. INFORMATION MAY BE FURNISHED BY THE PATIENT, PATIENT'S FAMILY AND /OR STAFF. IF, IN THE JUDGMENT OF CHIP ABERNATHY, LPC, DISCLOSURE OF THE PRIVILEGED/CONFIDENTIAL INFORMATION WILL BE HARMFUL TO THE PATIENT, RELEASE OF SUCH INFORMATION MAY BE WITHHELD IN ACCORDANCE WITH SPECIFIC STATE AND FEDERAL REGULATIONS. RECORDS RELEASED MAY CONTAIN ALCOHOL AND DRUG TREATMENT INFORMATION, PATIENT PHOTOGRAPHS, AIDS/HIV OR PSYCHIATRIC/PSYCHOLOGICAL OR MENTAL HEALTH PRIVILEGED OR CONFIDENTIAL INFORMATION. CERTAIN COMMUNICATIONS ARE PRIVILEGED AND NOT SUBJECT TO RELEASE WITHOUT YOUR CONSENT UNDER STATE AND/OR FEDERAL LAW.

AFTER GIVING DUE CONSIDERATION TO THE ABOVE STATEMENT, I AUTHORIZE CHIP ABERNATHY, LPC AND/OR MEMBERS OF HIS STAFF OR DESIGNEES TO FURNISH INFORMATION, INCLUDING ELECTRONIC, PHOTOSTATIC, EMAILED OR FAXED COPIES OF MY MEDICAL RECORD, INCLUDING MATTERS PRIVILEGED UNDER THE LAWS OF THE STATE OF GEORGIA, AND APPLICABLE FEDERAL LAWS AND REGULATIONS INCLUDING BUT NOT LIMITED TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA), TO THE ABOVE ORGANIZTION/INDIVIDUAL, OR TO ITS AGENTS.

I UNDERSTAND THAT THIS AUTHORIZATION IS SUBJECT TO REVOCATION, IN WRITING AT ANY TIME EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE THEREOF, AND REMAINS VALID FROM THE DATE OF MY SIGNATURE, UNLESS I SPECIFY A TERMINATION DATE HERE: _____.

_____ _____
DATE SIGNED PATIENT SIGNATURE

_____ _____
WITNESS SIGNATURE (LEGAL GUARDIAN IF APPLICABLE)/ RELATIONSHIP

PROHIBITION OF REDISCLOSURE: THIS INFORMATION MAY BE PROTECTED BY FEDERAL REGULATION (42 CFR PART 2) WHICH PROHIBIT YOU FROM MAKING FURTHER DISCLOSURE.