Gila Herman, PMHNP
6100 Lake Forrest Drive, Suite 450
Atlanta, GA 30342
(205) 671-4338
gilaherman@protonmail.com

I hereby authorize Gila Herman, PMHNP to

□ Release information to:
□ Obtain information from:
□ Communicate with:

Name _____
Address _____
_____
Phone Number _____
Email _____
Fax _____

The following information:
□ Medical history and evaluation(s)
□ Mental health evaluations
□ Developmental and/or social history
□ Educational records
□ Progress notes, and treatment or closing summary

The above information will be used for the following purpose:
□ Planning appropriate treatment or program
□ Continuing appropriate treatment or program
□ Determining eligibility for benefits or program
□ Case review
□ Updating files
□ Other

□ The parties stated above may discuss my medical and or mental health information without limitations.
□ I would prefer to limit the information shared between the parties stated above. The limitations are:

_____
_____
_____

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after 1 year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment on behalf of this individual.

Patient's Name	D.O.B.
Patient's Signature	Date
Parent/Guardian's Signature (if applicable)	Date