HILLSIDE INC.
AUTHORIZATION FOR RELEASE OF TREATMENT INFORMATION/MEDICAL RECORDS

Client Name: Date of Birth: ID Number:

Section I: Requesting/Releasing Party Information

I request and authorize Hillside: To release to: To obtain from:

Person/Professional/Facility/Agency Name:

Address:	City, State, Zip Code:
Phone Number:	Fax Number:

Section II: Types of Information To Be Released (please be specific)

Discharge Summary	Treatment Plan	Laboratory Results
History & Physical	Psychosocial History	Discharge Plan
Psychiatric Evaluation	Physician's Orders	Verbal communication/consultation
HIV/AIDS Confidential Information	Psychological Evaluation	Other: _____

Section III: Method of Transmission

Verbally in-person or by phone Email Fax Photocopy

Section IV: Purpose For The Release

At the request of the client/client representative	Evaluation/Treatment/Continuity of Care
Payment/Insurance	Legal
Social Security/disability	Other (state reason): _____

Section V: Expiration of Authorization

I understand that this authorization will remain in effect for (check one):

90 days post-discharge 90 days from the date of my signature Other date:

Section VI: Signature(s)

I understand that records released may contain HIV/AIDS, alcohol/drug treatment information or psychiatric/psychological information. I hereby voluntarily and knowingly **waive any applicable mental health privilege and confidentiality protections** under Georgia law and federal law, including the **Health Insurance Portability and Accountability Act**, as they relate to the minor's mental health treatment, diagnosis, and related medical records.

Hillside and many other organizations and individuals such as physicians, hospitals and health plans are required by law (42 CFR Part 2 & 45 CFR 160/164) to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws. I acknowledge that I am not under any force or duress, and that my decision concerning disclosure of information is not contingent to provision of service.

Signature of Client or Legal Representative: _____ Date: _____

If signed by legal representative, **relationship to client**: _____

Section VII: Withdrawal of Authorization (Do not complete unless authorization is being withdrawn)

I understand that I have a right to withdraw this authorization at any time. I understand that if I withdraw this authorization, I must do so in writing and present my written withdrawal to the releasing person/agency. I understand that the withdrawal will not apply to information that has already been released in response to this authorization.

I withdraw this authorization to release information: _____ Date: _____