**Bethany B. Davis MD**

Board Certified Psychiatrist

6065 Roswell Road Ne Ste 820 Atlanta GA 30328

P: 470-223-0062 F: 404-255-2888

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth date: \_\_\_\_\_\_\_\_\_\_\_\_

I request and authorize Dr. Bethany B. Davis to release the health care information described below to / from :

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This request and authorization applies to only the following protected health information:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

during the following time period or dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Purpose(s) of this use/disclosure: At the request of the individual\_\_\_ OR

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorization expires on \_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ (or one year from date of signing).

I understand that, unless action already has been taken in reliance on this authorization, I may revoke this authorization at any time, except to the extent that action has been taken in reliance on the authorization, by making a written request to Dr. Davis. I understand that my records are confidential and will not be disclosed without my written consent unless under legal compulsion. I understand that this authorization does not extend to release of any HIV/Aids information unless I have indicated above. I further understand that the information authorized by this Release will be released to the authorized recipient only for the purpose noted above. I understand that the information used or released as a result of this authorization may no longer be protected by federal privacy laws and may be further used or released by persons or organizations receiving it without obtaining my authorization. I understand that I am entitled to receive a copy of this authorization.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature (patient or authorized representative) Date:

Relationship/authority (if signed by authorized representative): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This information has been disclosed to you from records protected by Federal confidentiality rules (42CFR Part 2) and/or state law. In accordance with federal and state law requirements, the information received pursuant to this document is confidential and recipient is prohibited from making further re-disclosure of this information to any other person or entity, or to use it for any purpose other than authorized herein without the written consent of the person to whom “I” pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate, prosecute any alcohol or drug patient.