STATESBORO PSYCHIATRIC ASSOCIATES

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Section A: Use or Disclosure of Health Information

By signing this Authorization form, I authorize the use or disclosure of my health information between the following entities:

Name: ____

Print the Name of the Person/Organization(s) holding this information

Address: ____

Phone/Fax: ____

and:

Statesboro Psychiatric Associates, P.C.
116 Hill Pond Lane • Statesboro, GA 30458
(912) 489-1629 • Fax (912) 489-1630

Health information includes information collected from me or created by the Provider, or information received by the Provider from another heath care provider, a health plan, my employer or a health care clearinghouse. Health information may relate to my past, present or future physical or mental health or condition, the provision of my health care, or payment for my health care services.

Section B: Scope and Use of Disclosure (Check One)

Health information that may be used or disclosed through this Authorization is as follows:

❑ All health information about me, including my clinical records, created or received by the Provider. This information may include, if applicable:

- Therapy Notes
- Information pertaining to the treatment of alcohol or drug abuse;
- Information concerning the testing for HIV and/or treatment of AIDS.

❑ All health information about me as described in the preceding checkbox, excluding the following: ______________________________
____
____

❑ Specific health information including only: ______________________________
____
____

Section C: Purpose of Use or Disclosure

The purpose(s) of this Authorization is (are):

❑ Specifically, the following purpose(s): ______________________________
____
____

Section D: Expiration

Once signed, this Authorization is in effect for one year from the date of signature, unless rescinded. ___________

Section E: Other Important Information

1. I understand that Statesboro Psychiatric Associates cannot guarantee that the Recipient will not re-disclose my health information to a third party. The Recipient may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of treatment information about a patient in a federally-assisted alcohol or drug abuse program, the Recipient is prohibited under federal law from making any further disclosure of such information unless further disclosures is expressly permitted by written consent of the patient or as otherwise permitted under federal law governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part 2).

2. I understand that, except when I am; (i) receiving research-related treatment or; (ii) receiving health care solely for the purpose of creating information for disclosure to a third party, I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment from Statesboro Psychiatric Associates.

3. I understand that I may revoke this Authorization in writing at any time, except that the revocation will not have any effect on any action taken by Statesboro Psychiatric Associates in reliance on this Authorization before written notice of revocation is received by Statesboro Psychiatric Associates. I further understand that I must provide any notice of revocation in writing to the Privacy Officer at 116 Hill Pond Lane, Statesboro, GA 30458.

Section F: Signatures

I read and understand the terms of this Authorization. I have had an opportunity to ask questions about the use or disclosure of my health information.

Patient's Signature: ________________________________ Date: ______________
*digital signature

Print Patient's Full Name: ________________________________ DOB: ______________

SS#: ______________

When the Patient is not permitted by law to give consent, the signature of a parent, guardian, health care agent (proxy) or other representative is required.

Relationship of Representative to Patient: ❑ Parent ❑ Guardian ❑ Health Care Agent (proxy) ❑ Other

If other, please specify relationship here: ________________________________

Legal Representative's Signature: ________________________________ Date: ______________
*digital signature

Print Representative's Full Name: ________________________________

Witness Signature: ________________________________ Date: ______________
*digital signature

Witness Signature: ________________________________ Date: ______________
(only needed if not signed by parent or patient's legal guardian)