PROGRESSIVE CARE ASSOCIATES, INC.
3415 Old Highway 41, Suite 750 Kennesaw, GA 30144 | (678) 574-8313 | FAX (678) 574-8315

BEHAVIORAL HEALTH SERVICES RELEASE OF INFORMATION

Effective One year FROM:_____ TO: _____

PATIENT'S NAME (Print): _____ DOB:_____

I AUTHORIZE _____ OR PROGRESSIVE CARE ASSOCIATES, INC TO ☐ RELEASE or ☐ OBTAIN INFORMATION TO/FROM:

_____

Specific Organization/Person **Address**

INFORMATION THAT MAY BE RELEASED:

☐Mental Health/Physical Information: ☐Presence and Progress in Treatment ☐Assessments ☐Diagnoses ☐Tx/Recovery Plans ☐Psychiatric Summary ☐Medication Records ☐Demographic Information

☐Drug/Alcohol Treatment Information: ☐Presence and Progress in Treatment ☐Assessments ☐Diagnoses ☐Tx/Recovery Plans ☐Psychiatric Summary ☐Medication Records ☐Demographic Information

_____HIV/AIDS Information
INITIALS

☐ Other: _____

REASON: ☐Provide continuity of care ☐Compliance with program ☐Specify _____
☐Personal Use ☐Legal Purposes ☐Social Security/disability ☐Insurance/Managed Care

DATES OF SERVICE: FROM _____ TO _____

I understand that my health information is protected under the federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2 that re-disclosure is prohibited, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. Parts 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer will be protected by the HIPAA Privacy Law. I further understand that I may: 1) review and understand the Notice of Privacy Practices; 2)this authorization is subject to revocation at any time, except to the extent that action has been taken in reliance on the authorization; 3)inspect and receive a copy of the material to be released; 5) request restrictions on how my health information is used and disclosed; and 6) receive a copy of this authorization and the Notice of Privacy Practices

This form has been fully explained and I certify that I understand its contents. I understand that Progressive Care Associates, Inc. may not condition treatment on obtaining this consent/authorization from me.

_____ _____
Patient's Signature or Oral Consent when physically unable to sign — Date
"I understand the nature of the release and freely give oral consent"

_____ _____
Signature of Authorized Person in lieu of Patient — Date
☐Power of Attorney; ☐Guardianship Order

_____ _____
Witness Signature — Date

_____ _____
Oral Consent/Witness Signature — Date