Norniella Behavioral Health
1353 Jennings Mill Rd. Suite C
Watkinsville, GA 30677
Phone:706-357-5467 Fax:706-357-5468

Request/Authorization to Release Confidential Records and Information

I ________________________________ SS#: ________________________ DOB: __________ hereby authorize Eastern Atlanta Behavioral Health LLC to release to or to obtain from:

Person or Facility:____

Address:____

____

Information related to: diagnoses, treatment goals, social history, treatment history (inpatient and/or outpatient), evaluation results, treatment recommendations, any other related information for the purpose of: (**What information can be released?)**____

I have read or had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may revoke this authorization at any time, except to the extent that action based on this consent has already been taken. I understand that the authorization will remain in effect for:

_____ One (1) Year unless I specify an earlier date here ___________________

_____ The period necessary to complete all transactions related to this authorization.

___________________________________ ________________________________ ____________
Signature of Patient Printed Name Date

___________________________________ ________________________________ ____________
Signature of Parent/Guardian/Representative Printed Name & Relationship Date

I witnessed that the individual listed above understood the nature of this request/authorization and gave his/her consent verbally due to an inability to physically provide a signature.

___________________________________ ______________________________
Signature of Witness Date