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

RELEASE OF INFORMATION

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

Full Name:_____ Patient DOB:_____

Social Security:_____ Contact Phone:_____

I authorize and request Norniella Behavioral Health to **release records to:** (this MUST be completed):

Name/Place:_____ Phone #:_____

Fax #: _____ Address:_____

What Information Can Be Released? (Please Check one)

- o I authorize the release of **My Complete Health Record** (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).
- o Communicable diseases (including HIV and AIDS)
- o Alcohol/drug abuse treatment
- o Lab Results
- o Billing Documents
- o Prepared Letters
- o Medication List

- This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
- I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
- I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
- I have read or had explained to me and fully understand this request/authorization to release or obtain 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