Providence Residential & Outpatient PTSD Services, LLC dba PROPS
and
Dr. Felicia Berry-Mitchell

Request/Authorization to Release Confidential Records and Information

A. Person or facility: Felicia Berry-Mitchell, PhD of Providence Residential & Outpatient PTSD Services, LLC dba PROPS

Address: 6576 Church St, Douglasville, GA 30134 Phone: 770-577-7873 Fax: 770-577-7871

B. Identifying information about me/the patient

Name: _____

Address: _____

Phone: _____ Birthdate: _____ Social Security #: _____

Parent/guardian (if applicable): _____

Address and phone of parent/guardian: _____

_____

C. I hereby authorize the source named above to send, as promptly as possible, the records listed below marked by an X in the boxes below. (The items not to be released have a line drawn through them.) Page numbers are indicated where appropriate. Written dates (other than those regarding inpatient admission/outpatient treatment) indicate when those records were mailed to the requester.

❑ Inpatient or outpatient treatment records for physical and/or psychological, psychiatric, or emotional illness or drug or alcohol abuse:

Date(s) of inpatient admission: _____

Date(s) of outpatient treatment: _____

Other identifying information about the service(s) rendered: _____

❑ Psychological evaluation(s) or testing records, and behavioral observations or checklists completed by any staff member or by the patient.
❑ Treatment plans, recovery plans, aftercare plans.
❑ Social histories, assessments with diagnoses, prognoses recommendations, and all similar documents.

❑ Workshop reports and other vocational evaluations and reports.
❑ Academic or educational records.
❑ Achievement and other tests' results.

❑ Psychiatric evaluations, reports, or treatment notes and summaries.

❑ Admission and discharge summaries.
❑ Information about how the patient's condition affects or has affected his or her ability to complete tasks, activities of daily living, or ability to work.
❑ Billing records.

❑ Report of teachers' observations.
❑ A letter containing dates of treatment(s) and a summary of progress.

HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here: ❑ Do not release HIV-related information ❑ Do not release drug and alcohol information.

Other: _____

_____

To:

Name:_____ Facility:_____

For purpose of:_____

_____

D. Select only one:
❑ Please forward the records to the address in the letter attached to this form.
❑ Please forward the records to the address written below.

E. I authorize the source named above to speak by telephone with the therapist identified in part N, below, about the reasons for my/the patient's referral, any relevant history or diagnoses, and other similar information that can assist with my/the patient's receiving treatment or being evaluated or referred elsewhere.

F. I understand that no services will be denied me/the patient solely because I refuse to consent to this release of information, and that I am not in any way obligated to release these records. I do release them because I believe that they are necessary to assist in the development of the best possible treatment plan for me/the patient. The information disclosed may be used in connection with my/the patient's treatment.

G. This request/authorization to release confidential information is being made in compliance with the terms of the Privacy Act of 1974 (Public Law 93-579) and the Freedom of Information Act of 1974 (Public Law 93-502); and pursuant to Federal Rule of Evidence 1158 (Inspection and Copying of Records upon Patient's Written Authorization). This form is to serve as both a general authorization, and a special authorization to release information under the Drug Abuse Office and Treatment Act of 1972 (Public Law 92-255), the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act Amendments of 1974 (Public Law 93-282), the Veterans Omnibus Health Care Act of 1976 (Public Law 94-581), and the Veterans Benefit and Services Act of 1988 (Public Law 100-322). It is also in compliance with 42 C.F.R. Part 2 (Public Law 93-282), which prohibits further disclosure without the express written consent of the person to whom it pertains, or as otherwise permitted by such regulations. It is in compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Public Law 104-191.

H. In consideration of this consent, I hereby release the source of the records from any and all liability arising therefrom.

I. This request/authorization is valid during the pendency of any claim or demand made by or in behalf of me/the patient, and arising out of an accident, injury, or occurrence to me/the patient. I understand that I may void this request/ authorization, except for action already taken, at any time by means of a written letter revoking the authorization and transfer of information, but that this revocation is not retroactive. If I do not void this request/authorization, it will automatically expire in 90 days from the date I signed it.

J. I agree that a photocopy of this form is acceptable, but it must be individually signed by me, the releaser, and a witness if necessary.

K. I have been informed of the risks to privacy and limitations on confidentiality of the use of electronic means of information transfer, and I accept these.

L. I affirm that everything in this form that was not clear to me has been explained. I also understand that I have the right to receive a copy of this form upon my request.

M. Signatures:

_____	_____	_____
Signature of client	Printed name	Date

_____	_____	_____	_____
Signature of parent/guardian/representative	Printed name	Relationship	Date

I witnessed that the person understood the nature of this request/authorization and freely gave his or her consent, but was physically unable to provide a signature.

_____	_____	_____
Signature of witness	Printed name	Date

N. I, a mental health professional, have discussed the issues above with the patient and/or his or her parent or guardian. My observations of behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____	Felicia Berry-Mitchell, PhD	_____
Signature of professional	Printed name	Date

❑ Copy for patient or parent/guardian ❑ Copy for source of records ❑ Copy for recipient of records