SOUTHERN CRESCENT BEHAVIORAL HEALTH SYSTEM

Anchor Hospital Campus
5454 Yorktowne Drive
Atlanta, GA 30349
Phone: 770-991-6044
Fax: 678-251-3271

Authorization for Release of Information

Crescent Pines Campus
1000 Eagles Landing Pkwy.
Stockbridge, GA 30281
Phone: 770-474-8888
Fax: 678-593-4805

Patient Name: Dates of Treatment:

Social Security Number: Birth Date:

Information to be disclosed by: ☐ Anchor Hospital Campus 5454 Yorktowne Drive Atlanta, GA 30349
☐ Crescent Pines Campus 1000 Eagles Landing Pkwy Stockbridge, GA 30281

Information to be disclosed to: Name/Agency

Address

Purpose for Release:	☐ Continuity of Care ☐ Education Credit ☐ Legal Representation ☐ Other:

Information to be Disclosed: ☐ Discharge Summary Dated: _____

☐ Dates of Hospitalization	☐ Initial Clinical Assessments	☐ Treatment Plan & Updates
☐ History & Physical Exam	☐ Lab/X-Ray Reports	☐ Psychosexual Assessment
☐ Admission Face Sheet	☐ Psychosocial Assessment	☐ Consultation Reports
☐ Physician Orders	☐ Psychiatric Evaluation	☐ Medication Records
☐ Educational Assessment	☐ Psychological Evaluation	☐ Progress Notes
☐ School Records	☐ Discharge/Continuing Care Plan	☐ Other:

Date or event upon which this consent expires: _____
Not to exceed one year. If an expiration event is used, the event must relate to the purpose for the disclosure

I understand that Southern Crescent Behavioral Health System cannot guarantee the recipient of this information will not re-disclose the 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 an alcohol or drug abuse program, the recipient is prohibited under federal law from making any further disclosure of the information unless further disclosure is expressly permitted by the patient's written consent or otherwise permitted by the law governing alcohol and drug abuse records (42 CFR, Part 2).

I also understand that except when 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 services from Southern Crescent Behavioral Health System.

I realize that the records being exchanged may contain alcohol and drug treatment information; AIDS/HIV information; or psychiatric, psychological, or psychosexual information. Furthermore, I understand that I may revoke this Authorization in writing at any time, except to the extent that action has already been taken. If I choose to revoke this authorization, Southern Crescent Behavioral Health System reserves the right to notify the above-named person or agency of the revocation.

Signature of Patient:	Date:	Time	AM/PM
Signature of Witness:	Date:	Time	AM/PM
Signature of Parent/Guardian:	Date:	Time	AM/PM

Use this space to revoke authorization

Signature of Patient/Guardian:	Revocation Date: