**NEURO BEHAVIORAL HEALTH ASSOC LLC**

367 Athens Hwy Ste 1800, Loganville, GA 30052, 770-554-2999 Office, 770-679-6390 Fax

1026 Twelve Oaks Drive Ste A, Watkinsville, GA 30677, 706-521-0999 Office, 770-679-6390 Fax

**Authorization to Release Sensitive Protected Health Information Form**

Patient _____ Date:_____

DOB:_____ SSN (Last 4 Digits): _____XXX-XX-_____

Person Requesting Release (Patient/Parent/Guardian): _____

Address: _____

City: _____ State: _____ Zip: _____

Releasing Agency/Practice/Clinician: _____

Address:_____

City: _____ State: _____ Zip: _____

Office Number: _____ Fax Number: _____

(If Applicable) NBHA may disclose this PHI to: Agency/Company):_____

Address: _____City: _____State: _____ Zip: _____

Office Number: _____ Fax Number:_____

The following type(s) of information from my records (and any specific portion thereof) to be released to Neuro Behavioral Health Associates LLC:

☐ All health care information in my medical record

☐ Health care information in my medical record for the dates specified:_____

☐ Other: (labs, bills, etc) Please specify:

☐ Mutual exchange of information

This information may include Medical/Surgical, Psychiatric, Substance Abuse, and HIV/AIDS information.

**For the purpose of:**

All information I hereby authorize to be obtained from this agency will be held strictly confidential and cannot be released by the recipient without my written consent. I understand that this authorization will remain in effect for:

One (1) year, **unless** I specify an earlier expiration date here:_____.
Date

The period necessary to complete all transactions on accounts related to services and treatment provided by Neuro Behavioral Health Associates, LLC. Please fax (770-679-6390) or mail all requested information to NBHA LLC.

_____ _____

Signature Patient/Responsible Party Date

_____ _____

Signature of Witness Date

**USE THIS SPACE ONLY IF CONSENT IS WITHDRAWN**

_____ _____Patient/Responsible Party

Date Consent if Revoked by Patient