Niti Patel, M.S.
1755 Woodstock Road
Roswell, GA 30075
770-910-2753
www.cornerstonefamilyservices.com

RELEASE OF INFORMATION

Regarding ___________________ [Client] whose date of birth is __________, I ___________________ [Client/Guardian Completing ROI] authorize Niti Patel, MS to disclose to and/or obtain information from: *(Must be an Individual's Name)*

Name: ____ Phone: ____

Address: ____

Description of Information to be Disclosed or Obtained
(please initial each item to be disclosed)

_____ Clinical Assessment (if applicable)
_____ Treatment Plan or Summary
_____ Current Treatment Update/Progress
_____ Psychiatric Evaluation/Diagnosis(es)
_____ Laboratory Reports
_____ School Information
_____ Social History
_____ Attendance/Participation in Treatment
_____ Dates/Times of Treatment
_____ Continuing Care Plan
_____ Demographic Information
_____ Full Treatment Record*
*(*cannot be combined with any other disclosure)*
_____ Other ____________________________________

Purpose
The purpose of this disclosure of information is to improve assessment, treatment coordination, treatment planning, and share information relevant to treatment process when appropriate.

If the purpose is other than as specified above, please specify:

____

Revocation
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Niti Patel at Its Time We Talk Therapy LLC. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration
I understand that this authorization will remain in effect *ONE (1) YEAR* from signed date, unless sooner revoked or another choice of date (not to exceed 365 days of signature) is indicated here: _________________________.

Form of Disclosure
Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

_____ **By checking here, I agree that information may be shared electronically with other professionals via email. I understand that the security of email servers cannot be guaranteed, and I accept the risk associated with electronic transfer of information. I will be given a copy of this authorization for my records, if I request.**

Redisclosure
I understand that there is the potential that the protected health information (PHI) that is disclosed pursuant to this authorization may be redisclosed or misused by the recipient and the PHI will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

Medical records frequently contain information which may be privileged and/or confidential. This could include remarks furnished by the client, client's family, or medical staff. If, in the judgment Niti Patel's disclosure of the privileged/confidential information will be harmful to the client, release of such information may be withheld in accordance with specific state and federal regulations. Records released may contain alcohol and drug treatment information, AIDS/HIV, psychiatrics/psychological/and other mental health privileged/confidential information. Certain communications are privileged and not subject to release without your consent understate and/or federal law.

After giving due consideration to the above statement, I authorize Niti Patel, MS to furnish/receive information, including faxed copies of my Protected Health Information (PHI), including matters privileged under the laws of the state of Georgia, and applicable federal laws and regulations, to the above person(s). I further agree to indemnify and hold harmless Niti Patel and Its Time We Talk Therapy LLC from all liability that may arise from the release of the information herein requested.

____
Signature of Client **Date**

____
Signature of Guardian or Personal Representative **Date**
If you are signing as a personal representative of an individual, please describe your authority to act for this individual (i.e. power of attorney, healthcare surrogate, etc.).

____
Signature of Staff Witness **Date**

_____ Check here if client refuses to sign authorization.