Athens Concussion & Neuropsychology Center, LLC
General and Mental/Behavioral Health Records Release and Authorization for Use or Disclosure of Protected Health Information

Please complete the following information:

Patient Name: _____
Address: _____
_____
Phone: _____
Last four SSN: _____ Date of Birth: _____ /_____ /_____

I authorize the custodian of records of (Provider/entity): _____
Address: _____
Phone/Fax: _____

To disclose/release the following information * (check all that apply):

- ☐ All records **(including mental/behavioral health records)**
- ☐ Office notes (previous 2 years)
- ☐ Neuropsychological testing records
- ☐ Psychological testing records
- ☐ Psychotherapy/psychological records (previous 2 years)
- ☐ Radiology records (previous 3 years)
- ☐ Pharmacy/prescription records
- ☐ Billing records
- ☐ Other: _____

Note: If these records contain any information from previous providers, or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted infections/diseases, you are hereby authorizing disclosure of this information.*

Please send the records listed above to:

Athens Concussion & Neuropsychology Center, LLC
Dr. Katherine J. Finley, PhD
575 Research Drive Suite B
Athens, GA 30605-2779
Phone: 706-850-9339
Fax: 706-850-2160

This authorization shall not be valid for greater than one year from the date of signature.

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below, I represent and warrant that I have authority to sign this document and authorize the use of disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____
Signature of Patient (or Patient's Representative) Date

_____ _____
Printed name of Patient, or Representative Representative's authority to sign (POA, parent, guardian, executor, etc)

You have the right to revoke this authorization, except to the extent of the custodian of records has relied on it, by sending your written request to: Athens Concussion & Neuropsychology Center, Attn: Office Manager, 575 Research Dr. Ste B, Athens, GA 30606-2779