Positive Outcomes Psychological Services, P. C.
Harvey L. Gayer, Ph.D., GCSP, Director
Licensed Psychologist (GA 2137)
Nationally and State Certified School Psychologist
485 Huntington Rd., Suite 201, Athens, GA 30606
Office 706-546-8440 Fax 706-546-8456

Authorization to Use or Disclose Protected Heath Information (PHI)

Section 1. Who is the Patient?

Last Name	**First Name**		**Middle Intial**
Subscriber Number from ID Card			
Insurance Company Name			
Date of Birth (mm/dd/yyy)			
Phone Number (s)			
Street Address			
City	**State**	**Zip**	

I hereby authorize the use or disclosure of protected heath information about the individual named above. I am:

__ the individual named above (complete section 8 below to the sign this form)

__ a personal representative because the patient is a minor, incapacitated, or deceased (complete section 9 below)

Section 2. Who Will Be Disclosing Information About the Individual?

The following person(s) or entity may use or disclose the information:

Name (a person, a class of persons like "doctors who treated me in August 2003," or an organization)
Phone Number
Street Address
City, State, Zip

Section 3. Who Will Be Receiving Information About the Individual?

This information may be disclosed to:

Name (a person, a class of persons like "family members residing with me", or an organization
Phone Number
Street Address
City, State, Zip

Section 4. What Information About the Individual Will Be Disclosed?

Please specify the type of behavorial health and/or substance abuse services information to be disclosed, including any relevant dates.

____

Section 5. What is the Purpose of this Disclosure?

Please give the reason the information is being requested or disclosed. ___________________________

Section 6. What is the Expiration Date or Event?

This authorization must expire within 1 year, on either a specific date or upon a specific event. Please choose either

- the following expiration date (no more than 1 year from today: ______
- the following specific event (needs to happen within 1 year): _______

Section 7. Important Rights and Other Required Statements You Should Know

- You can revoke this authorization at any time by writing to: Dr. Harvey Gayer, 485 Huntington Road, Suite 199, Athens, GA 30606. If you revoke this authorization, it will not apply to information that has already been used or disclosed.
- The information disclosed bases on this authorization may be redisclosed by the recipient and may no longer be protected by federal or state privacy laws. Not all persons or entities have to follow these laws.
- You do not need to sign this form in order to obtain enrollment, eligibility, payment or treatment for services.
- This authorization is completely voluntary, and you do not have to agree to authorize any use or disclosure.
- You have a right to a copy of this authorization once you have signed it. Please keep a copy for your records, or you may ask us for a copy at any time by writing to the same address as above.
- If you have any questions about anything on this form, or how to fill it out, we can help.

Section 8. Signature of the Individual

Signature: _______________________________Date: ________________________

Section 9. Signature of Personal Representative (if applicable)

Signature: _______________________________ Date:_________________________

Please describe your relationship to the individual and /or your legal authority to act on behalf of this individual in making decisions related to healthcare. You may be asked to provide us with relevant legal document giving you this authority.

Relationship to the individual (required): _______________________________________