

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the release of information between (to and/or from):

Name: _____ Cindi Bockwitz
Address: _____ 558 Medlock Rd. Suite A
_____ & Decatur, GA 30030
Phone: _____ 404.702.2007 (vm)
Fax: _____ 1.413.513.9503 (fax)

To disclose records and/or information concerning: _____

Name(s)

for the following purpose(s);

___ Assessment/Diagnosis ___ Treatment ___ Consultation ___ Medication Assessment
___ Other: _____

and will be limited to the following specific written and/or verbal information:

___ Outpatient treatment summary ___ Treatment Plan ___ Medication
___ Hospital admission/discharge summaries ___ History and Physical
___ Results of psychological testing/assessments ___ Medical Records
___ Other: _____

HIPAA PRIVACY STATEMENT

In accordance with federal HIPAA regulations, I am required to include this disclosure statement in this report. This information has been disclosed to you, the confidentiality of which is protected by Georgia law. The HIPAA regulations prohibit making any further disclosure of the information without the specific written consent of the Court or the person (or legal guardian) to whom it pertains or as otherwise permitted by regulations governing therapists. A general authorization for the release of medical or other information is not sufficient for this purpose. This report is strictly confidential and is intended to provide information only for the person to whom it is addressed. No responsibility can be accepted if it is made available to any other agency, insurance carrier, or person, including the patient. This Notice is in effect April 14, 2003.

This authorization is subject to revocation (cancellation) by me at any time except to the extent that action has already been taken. If not earlier revoked, this authorization shall expire 90 days from the date of signature.

Signed: _____ Date: _____
Signed: _____ Date: _____

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