Chip Abernathy, LPC
1260 Concord RD, Suite 205, Smyrna, GA 30080. Telephone (770) 862-7585

RELEASE OF INFORMATION TO PERSONS IN SUPPORT SYSTEM

I, (Please print name clearly) ____,
Date of Birth_____________, authorize Chip Abernathy, LPC to communicate by telephone, text, email, letter or in person with:

NAME:	RELATIONSHIP:	TELEPHONE NO.:
____________________________________	____________________	________________________
____________________________________	____________________	________________________
____________________________________	____________________	________________________

I authorize any of the following information to be released: My participation in counseling/psychotherapy; discussion of information pertinent to my care; scheduling of appointments; education about treatment expectations or discharge options; and/or contact in case of emergency or clinical concern.

The purpose of this communication is to: Advise the above-named individual(s) of: my involvement and/or progress in counseling/psychotherapy; discussion of information pertinent to my care; schedule appointments; educate the above-named individual(s) about treatment expectations or discharge options; and/or contact in case of emergency or clinical concern.

I AGREE TO INDEMNIFY AND HOLD HARMLESS CHIP ABERNATHY, LPC AND STAFF/DESIGNEES FROM ALL LIABILITY THAT MAY ARISE FROM THE RELEASE OF THE INFORMATION HEREIN REQUESTED.

HEALTHCARE INFORMATION MAY BE PRIVILEGED AND/OR CONFIDENTIAL. THE PATIENT, PATIENT'S FAMILY AND / OR DESIGNEES MAY FURNISH INFORMATION. IF, IN THE JUDGMENT OF CHIP ABERNATHY, LPC, DISCLOSURE OF THE PRIVILEGED/CONFIDENTIAL INFORMATION WILL BE HARMFUL TO THE PATIENT, RELEASE OF SUCH INFORMATION MAY BE WITHHELD IN ACCORDANCE WITH SPECIFIC STATE AND FEDERAL REGULATIONS. INFORMATION RELEASED MAY BE RELATED TO ALCOHOL AND OTHER DRUG TREATMENT INFORMATION, AIDS/HIV, PSYCHIATRIC, PSYCHOLOGICAL, OR MENTAL HEALTH PRIVILEGED OR CONFIDENTIAL INFORMATION. CERTAIN COMMUNICATIONS ARE PRIVILEGED AND NOT SUBJECT TO RELEASE WITHOUT YOUR CONSENT UNDER STATE AND/OR FEDERAL LAW.

AFTER GIVING DUE CONSIDERATION TO THE ABOVE STATEMENT, I AUTHORIZE CHIP ABERNATHY, LPC AND/OR MEMBERS OF HIS STAFF OR DESIGNEES TO FURNISH INFORMATION, INCLUDING VERBAL OR TEXTED INFORMATION VIA CELLULAR TELEPHONE, ELECTRONIC, PHOTOSTATIC, EMAILED OR FAXED LETTERS, INCLUDING MATTERS PRIVILEGED UNDER THE LAWS OF THE STATE OF GEORGIA AND APPLICABLE FEDERAL LAWS AND REGULATIONS INCLUDING BUT NOT LIMITED TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA), TO THE ABOVE INDIVIDUAL/ ORGANIZTION OR TO ITS AGENTS. IN ALL OF THESE INSTANCES, CONFIDENTIALITY WILL BE PROTECTED AS WELL AS POSSIBLE, BUT IS LIMITED DUE TO THE RISK OF THE INFORMATION BEING OVERHEARD OR ENDING UP IN THE WRONG HANDS. PRECAUTIONS WILL BE TAKEN WHEREVER POSSIBLE.

I UNDERSTAND THAT THIS AUTHORIZATION IS SUBJECT TO REVOCATION, IN WRITING, AT ANY TIME EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE THEREOF, AND REMAINS VALID FROM THE DATE OF MY SIGNATURE UNLESS I SPECIFY A TERMINATION DATE HERE: _________________ .

____ _________________
Patient signature Date

____ _________________
Parent or guardian signature (if applicable) Date

____ _________________
Witness signature Date

PROHIBITION OF REDISCLOSURE: THIS INFORMATION MAY BE PROTECTED BY FEDERAL REGULATION (42 CFR PART 2), WHICH PROHIBITS FURTHER DISCLOSURE.