

Chip Abernathy, LPC LLC

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RELEASE OF INFORMATION TO AND FROM PERSONS IN SUPPORT SYSTEM

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

NAME / RELATIONSHIP:	TELEPHONE NO.	EMAIL ADDRESS:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

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

AFTER GIVING DUE CONSIDERATION TO THE ABOVE STATEMENT, I AUTHORIZE CHIP ABERNATHY, LPC AND/OR MEMBERS OF HIS STAFF OR DESIGNEES TO FURNISH INFORMATION VIA CELLULAR TELEPHONE, ELECTRONIC, PHOTOSTATIC, EMAILED OR FAXED COPIES OF THE INFORMATION NOTED HEREIN TO BE RELEASED, 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 ORGANIZATION/INDIVIDUAL, 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 I may revoke this authorization at any time except to the extent that action has already been taken. It 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. REVISED 11-04-23