MATT F. BUTRYN, PH.D., LLC
ATHENS NEUROPSYCHOLOGY AND COUNSELING
AUTHORIZATION FOR RELEASE OF
PROTECTED HEALTH INFORMATION (PHI)

_____	_____	XXX-XX-_____
Name of Client	Date of Birth	Identification #

I HEREBY AUTHORIZE:
Matt F. Butryn, Ph.D., LLC
1 Huntington Road, Suite 802
Athens, GA 30606
Phone: 706-548-0018
Fax:706-548-2389

TO RELEASE TO AND RECEIVE FROM:

_____
(Attorney/ Agency/ Physician/ Other)

_____
(Street Address)

_____
(City, State, Zip Code)

_____
(Telephone or Fax #)

By signing this release of information, I give my consent for Dr. Butryn and his agent(s) to perform all of the following:

1. Release all applicable information to this source
2. Obtain applicable information from this source
3. Talk face to face with this source
4. Have phone contact with this source
5. Fax to and receive faxes from this source regarding all applicable information
6. A photocopy of this signed document can replace the original
7. Other _____

PLEASE CHECK INFORMATION REQUESTED:

□ All Applicable Information □Discharge Summary □Individual Service Plan
□ Initial Evaluation □ Progress Notes □Medications □Physician's Orders
□Other _____

I understand and agree that:

1. I may revoke this authorization at any time in writing and present my written revocation to this office.
2. The revocation will not apply to information that has already been released in response to this authorization.
3. I may refuse to sign this authorization.
4. Disclosure of health information is voluntary.
5. I need not sign this authorization to ensure treatment nor will it affect my payment status.
6. Any disclosure of information carries with it the potential for an unauthorized redisclosure.
7. I may inspect or have a copy of the information described on this form if I ask for it, unless otherwise prohibited by law.
8. I can get a copy of this form after I sign it if I request that.

All information I hereby authorize to be obtained from this agency will be held strictly confidential and cannot be released without my consent. I understand this authorization includes the release of all medical records including Drug/Alcohol treatment records, HIV/ AIDS record, Psychiatric records, Venereal Disease records, and other statutorily protected disease records.

If I have any questions about the disclosure of my protected health information, I can contact this practice's Privacy Officer. I have read the above and authorize the disclosure of the protected health information as stated. If I fail to specify an expiration date, this authorization will expire in one (1) year from the date of the signature.

THIS AUTHORIZATION EXPIRES ON: _____

_____ _____
(Signature of Client or Legal Representative) (Date)
Relationship of individual to client: _____

_____ _____
(Witness) (Date)