

Member Information

Member Name: _____ DOB: _____
 Gender: _____ SS #: _____
 Address: _____ Phone #: _____

I hereby request and authorize: AID Atlanta, Inc.
 1605 Peachtree Street NE,
 Atlanta, Georgia 30309
 Phone: (404) 870-7700
 Fax: (404) 870-7809

To Obtain/Release from/to: Name: _____
 Address: _____
 Phone: _____

- The following type(s) of information from my records:**
- Medical records
 - Mental Health Records
 - Substance Abuse Treatment Records
 - Social Work or Case Management records
 - Legal or Power of Attorney documents
 - Other (specify): _____

For the purpose of: Continuity and Coordination of Care

All information I hereby authorize to be obtained and released to and from the above named entity will be held strictly confidential and cannot be released by the recipient without my written consent. This authorization also authorizes AID Atlanta and the above named entity to verbally discuss my case for the purpose of ensuring adequate coordination of my services, treatment and care. I also understand that this authorization will remain in effect unless revoked by me in writing. I understand that it is my right to revoke this authorization in writing at any time.

I authorize the above named entities to (when necessary) correspond regarding my case through the use of:

- | | | | |
|-------------------------|--|-----------|--|
| Postal mail | <input type="checkbox"/> YES <input type="checkbox"/> NO | In Person | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Electronic mail (email) | <input type="checkbox"/> YES <input type="checkbox"/> NO | Telephone | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Facsimile transmittals | <input type="checkbox"/> YES <input type="checkbox"/> NO | | |

I understand and agree that AID Atlanta is not liable or responsible for any security risks associated with electronic, email or facsimile correspondence that may be intercepted erroneously by a third party.

This release expires: 1 Year 3 Months Other (specify): _____

Member Signature: _____ Date: _____

Witness Signature: _____ Date: _____