



Patricia Dunsha, PhD ABD, LPC, NCC, HS-BCP

551 N Cherokee Rd
P.O. Box 689
Social Circle, GA 30025

Main: 770-825-8124
Fax: 770-825-9066
Patricia@myonestopdoc.com

AUTHORIZATION FOR RELEASE OF HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth: _____

Previous Name: _____ SS#: _____

I request and authorize _____ to
Communicate via phone, email, or in writing to:

Name: Patricia Dunsha, LPC, NCC / Behavioral Innovations, LLC

Address: P.O. Box 689 551 N Cherokee Rd

City: Social Circle State: GA Zip Code: 30025

This request and authorization applies to: Communication with School (teachers, counselor, etc.)

[X] As follows: Communication with all providers of care to include verbal and written correspondence regarding patient's condition and progress.

Name/Address/Phone of doctor: _____

If a child, communication with school personnel to include verbal and written correspondence regarding patient's grades and progress, as well as behavior or additional concerns; email correspondence with patient's teachers, counselor, etc. Please list teacher name(s) that you want to contact us, as well as counselor, etc. EMAIL addresses are best:

[] Yes [] No I authorize the release of any records regarding substance use/abuse information and/or treatment to the person(s) listed above.
[X] Not applicable

Patient Signature: _____ Date Signed: _____
Parent or Guardian if Patient is a Minor

THIS AUTHORIZATION REMAINS IN EFFECT FOR TWO YEARS AFTER THE DATE SIGNED
or at the time the patient or parent/guardian revokes it.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that I may inspect and have a copy of the health information described in this authorization. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule. I affirm that everything in this form that was not clear to me has been explained and I believe I now understand all of it. My signature above acknowledges that I was offered a copy of this completed form.