

CUMBERLAND PSYCHIATRIC GROUP
P.O. BOX 1509 ROSWELL, GA 30077
PHONE 770-436-9700
Fax 678-736-7308

Authorization to Release Information

RE: _____ D.O.B: _____ SSN: _____

Address: _____

Best Daytime Number: _____

Print name of Parent/Guardian (if request is for a minor) _____

Information Requested/Released:

- Evaluation/Progress Notes
- Lab &/or Radiology tests
- Other: _____
- I consent to the release of alcohol &/or drug information
- I **DO NOT** consent to the release of alcohol &/or drug information

I hereby request and authorize **The Cumberland Psychiatric Group** to **release** any and all information indicated **to**:

Name _____

Address _____

Telephone: _____ Fax: 888-272-1215 _____

I understand that all information I hereby authorize to be obtained will be held strictly confidential and cannot be released without my written consent. I understand that this authorization will remain in effect for up to one year from this date.

I understand that unless otherwise limited by state or federal regulations, and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time by submitting my request in writing.

Date: _____ Signature of Client/Guardian _____

Date: _____ Signature of Witness _____

NON-COVERED SERVICES AGREEMENT

Fees for ancillary services such as copies of medical records, reports, third-party letters, medical leave forms, formulary questions and appeals, etc. are not covered by most insurance plans. Fees for these services are defined by CPG and are based on copy costs and the amount of time required by clinical and administrative staff. The following rates will apply:

Standard \$50.00
Extensive: Charges based on time and complexity

I understand that this is a non-covered service based upon my current insurance benefits and is to be paid at the time of service and is not reimbursable by my insurance plan.

Signature: _____ Date: _____