Georgia Neurobehavioral Associates LLC

140 E. Marietta St. Suite 301, Canton 30114
T: 770.213.3594 F:770.213.3595
Email: info@georgianeurobehavioral.com

CONSENT & AUTHORIZATION TO RELEASE INFORMATION

The following is an authorization for the stated parties to consult with your primary care physician or another party regarding your treatment process. Information shared is for the sole purpose of facilitating maximum care to you as the patient. Please provide the necessary information and your signature with today's date as indicated below.

****

I, _____ (patient name)

_____ (parent/guardian-if applicable),

hereby authorize Georgia Neurobehavioral Associates (GNA) provider (please circle all that apply):

Dr. Allison Doerr Dr. Diane Hollander Dr. David Brunette Dr. Peyton Groff Dr. Jack Talley Dr. Deborah Freudenthal

Gayle Wilkins Dian Stevenson Amy L. Brown Andrew Baugh Katrina Bayley Victoria Wills Ben Harris

(GNA doctor/therapist name(s) and my primary care physician and the following party or parties listed below to discuss my mental health treatment information and disclose records obtained in the course of psychological evaluation and therapy, psychiatric evaluation and treatment, ABA services, and neurofeedfeedback, including, but not limited to diagnosis and all clinical information about me as may be necessary to monitor the continuity of my care and to inform my primary care physician or other individuals listed below of my health status.

1. Primary Care Physician

Name:_____

Address: _____
_____

Ph: _____

Fax: _____

2. Other

Name:_____

Address: _____
_____

Ph: _____

Fax: _____

Please note that treatment is not conditioned upon your signing this authorization, and you have the right to refuse to sign this form.

Please indicate your preference regarding the information to be shared:

____ The parties stated above may discuss my medical and/or mental health information without limitations.

____ I would prefer to limit the information shared between the parties stated above. I understand that Under certain legal circumstances limiting information may not be possible. The limitations I would like to make are as follows:

_____
_____

Additionally, the above named parties, therapist & person(s) or entity (entities) designated under (1) or (2), agree to exchange information only between themselves (or their agents). Any disclosure of information extended beyond these parties is considered a breach of confidentiality.

Your signature below indicates that you understand that you have a right to receive a copy of this authorization. Your signature also indicates that you are aware that any cancellation or modification of this authorization must be in writing, and you have the right to revoke this authorization at any time unless Georgia Neurobehavioral Associates stated above has taken action in reliance upon it. This authorization becomes effective on the date below and automatically expires within (1) year of its effective date. I understand that this authorization does not extend to the release of any AIDS/HIV information unless I have also placed my initials here_____. Additionally, if you decide to revoke this authorization, such revocation must be in writing and received by the above named doctor at Georgia Neurobehavioral Associates, P.O. Box 5915, Canton GA, 30114 to be effective.

Client's Signature: _____ Date: _____

Parent's/Legal Guardian's Signature:_____ Date: _____

•Psychological Services •Psychiatric Services •Applied Behavior Analysis •Educational Services •Professional Consultation

Amy Brown, BCaBA
Andrew Baugh, MEd, BCBA
Katrina Bayley, MS, BCBA
Gayle Wilkins, EdD, RBT
Victoria Wills, BS, RBT
Ben Harris, MEd, RBT

GEORGIA NEUROBEHAVIORAL ASSOCIATES

Allison C. Doerr, PhD, BCBA-D
Diane L. Hollander, PsyD, BCBA-D
Jack L. Talley, PhD
Deborah Freudenthal, PhD
Peyton Groff, PhD, NCSP
David D. Brunette, MD
Dian Stevenson, MA, LPC

Date: _____

Primary Care Physician Name: _____
Primary Care Physician Practice Name: _____
Primary Care Physician Address: _____
City, State and Zip Code: _____

Patient Name: _____

Dear Dr. (Physician's Name): _____

Your patient (name) _____ (DOB): _____ has identified you as their primary care physician. In my work with this patient we have discussed the importance of coordinating an individual's total health care across health care professionals. In response to this discussion, (name/parent/guardian) _____ has given his/her consent for me to contact you, introduce myself as his/her behavioral health care practitioner and work directly with you when necessary.

At the present time (name) _____ has been in care with me since (date of intake appointment) _____.
In my continued work with this patient I will be in touch with you as changes occur which would be pertinent to our coordination efforts. Please note, ***this is not a request for information or records.***

As this patient's overall health care is of primary importance, I will be available to you and can be reached at 770-213-3594.

I look forward to our working together on an integrated approach for an optimal treatment outcome.

Respectfully,

Dr. Allison Doerr Dr. Diane Hollander Dr. David Brunette Dr. Peyton Groff Dr. Jack Talley Dr. Deborah Freudenthal

Gayle Wilkins Dian Stevenson Amy L. Brown Andrew Baugh Katrina Bayley Shannon Drabek Christy Hollander

PCP Fax Number: _____