Authorization to Release Information

Barry K. Hull, M.D.
A New Start Medical Center, Inc.
115 Habersham Drive, Fayetteville, GA 30214
Phone: 678-788-7500 Fax: 678-788-7501

_____ _____
Name of the patient receiving services at A New Start Medical Center – ANSMC *Date of Birth*

_____
Name of the individual or organization who will provide information to A New Start Medical Center

I give permission for the above-named individual(s)/organization(s) to provide information concerning the above named patient to Dr. Hull / A New Start Medical Center. This allows Dr. Hull and A New Start Medical Center to request and receive any and all information without restriction (this includes medical, psychiatric, psychological, school-related, work-related, etc. - i.e.: absolutely everything without restriction).

This information may be disclosed through direct conversation and/or through provision of written summaries, copies of previous treatment records, copies of academic records, and copies of any assessments or evaluations.

This release shall remain in effect until the patient states otherwise in writing.

I understand that I have the right to revoke this authorization at any time by sending written notification to A New Start Medical Center or the above-named individual/organization. Although the revocation will not apply to any information already disclosed, it will prohibit further request for or disclosure of information.

I also give permission for A New Start Medical Center to provide clinical information to the above-named individual/organization. The purpose of this release is to provide necessary clinical background information and to allow for ongoing coordination of appropriate care and treatment interventions.

_____ _____ _____
Patient's signature (or signature of the patient's parent/ guardian if the patient is a minor child) *Date* *Printed name of the parent/guardian who has signed on behalf of a minor patient (if applicable)*

_____ _____
Witness Signature *Date*