Atlanta Asylum Network

CONFIDENTIALITY AGREEMENT

I, the undersigned, understand that my participation with and any records of my disclosures to the Atlanta Asylum Network will be kept confidential and will not be revealed to third parties unless I specifically request this in writing. The law requires the following exceptions under which Atlanta Asylum Network must disclose such information:

- When there is reasonable suspicion of child abuse or neglect, or evidence of elder abuse.
- When a person presents an imminent and/or potentially serious danger to self or others.
- When a subpoena results from litigation (such as a lawsuit) that you have initiated and that places your mental status at issue.

The Atlanta Asylum Network will share information with your lawyer or referral source if you sign the release form below.

_____ _____

Signature Date

AUTHORIZATION TO RELEASE RECORDS

I, _____, hereby authorize the Atlanta Asylum Network, 1525 Clifton Road, Atlanta, GA 30322 to release information regarding my psychological or medical condition to, and receive information from, the person or agency specified below:

_____

_____

_____

_____

_____ _____

Signature Date

Atlanta Asylum Network

CONSENT FORM

I, the undersigned, acknowledge that I have read and understood the following:

He leído y entiendo el siguiente:

- I am seeking psychological and/or medical evaluation services from the Atlanta Asylum Network:

  Estoy buscando servicios psicologicos y médicos de Sobrevivientes Internacional.

  Yes_____ No_____
  Initials Initials

- I agree to participate in a limited number of procedures that may include a medical exam, psychological interview, and psychological testing.

  I understand that I can stop at any time without giving a reason and without it affecting me and/or my case through the Atlanta Asylum Network.

  Yes_____ No_____
  Initials Initials

- The Atlanta Asylum Network is collecting data through these procedures that may be used in social science and clinical research. This data does not include personal information, such as my name, address, telephone number or any unique information that could lead to my personal identification. I understandable that if I am not comfortable with the use of data in this way, I can decline to participate. This will have no influence on the course or the outcome of my evaluation and treatment through the Atlanta Asylum Network.

  I agree to the use of these data in clinical research.

  Yes_____ No_____
  Initials Initials

_____ _____
SIGNATURE *Firma* DATE *Fecha*