Exhibit #2

STATE OF GEORGIA

COUNTY OF FULTON

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

Last Name, First Name, Middle Initial Date of Birth (Mo/Day/Year) Master ID

SECTION I. ENTITIES AUTHORIZED TO SHARE PROTECTED HEALTH INFORMATION

I authorize the entities listed below to release, disclose, use, receive and/or exchange among them my Protected Health Information ("PHI") for the purpose of coordinating my medical and/or behavioral health treatment, or for providing me with social services including housing, government benefits, food, clothing, shelter, education, and/or employment. Eligible information to be disclosed by this Release of Information ("ROI") does not include any type of medical records.

Initial next to each provider with whom you authorize release of information.

— Fulton County Department of Behavioral Health and Developmental Disabilities (DBHDD)

— Grady Health Systems

— Atlanta Policing Alternatives and Diversion (PAD)

— GA Homeless Management Information System

— Fulton County Superior Court

— Fulton County Public Defender's Office

SECTION II. AUTHORIZATION FOR COURT SYSTEMS

I further authorize the entities listed below to release, disclose, use, receive and/or exchange among them my Protected Health Information ("PHI") for the purpose of coordinating my medical and/or behavioral health treatment, or for providing me with social services including housing, government benefits, food, clothing, shelter, education, and/or employment. Pursuant to the authorizations for entities listed below, I authorize my legal representation of record, in any criminal or civil matter, to revoke such authorizations on my behalf, at any time. I understand that my revocation of authorization specific to the entities below will not invalidate my authorizations indicated in Section I of this document. **Initial next to providers with whom you authorize release of information.**

— Fulton County Department of Behavioral Health and Developmental Disabilities (DBHDD)

— Grady Health Systems

— Atlanta Policing Alternatives and Diversion (PAD)

— GA Homeless Management Information System

— Fulton County Superior Court

— Fulton County Public Defender's Office

SECTION III. DESCRIPTION OF PROTECTED HEALTH INFORMATION

I permit the entities listed in Section I, Section II and those specified in Section V, if any, to share information in my files related to my care, treatment and social services as well as to discuss appropriate care, treatment, and social services with each other. This information will be used to coordinate and ensure appropriate applications

for, enrollment in, and eligibility for health care and social services, as well as to determine benefits I receive or that I may be able to receive and claims that seek payment for these benefits.

By signing this Authorization, I specifically permit the entities listed in Section I, Section II, and those specified in Section V, if any, to share my health information that relates to the following types of services I receive (if any):

- Physical Health
- Behavioral Health
- Drug abuse treatment, prognosis, or referral
- Social Services

This authorization does not include medical records, pharmacy records, or psychotherapy notes.

SECTION IV. EXPIRATION OF AUTHORIZATION

This Authorization will expire one (1) year from the date of signature. If and when a Revocation of Authorization is received, the Fulton County Department of Behavioral Health and Developmental Disabilities will cancel the Authorization, effective immediately.

SECTION V. OTHER IMPORTANT INFORMATION

1. I have a right to receive a copy of this Authorization. A copy of this Authorization is as valid as the original.
2. I have the right to refuse to sign this Authorization and remain eligible to receive treatment or services from any of the providers listed in Section I, Section II or specified in Section V.
3. I have the right to revoke, by and through my legal representation, the authorizations to entities listed in Section II, at any time.
4. I have the right to revoke this Authorization in writing prior to the expiration date listed in Section III. Depending on when I elect to revoke this Authorization, authorized entities listed herein may have already shared some or all available PHI prior to receiving notice of revocation.
5. If my Protected Health Information includes information about mental health or developmental disability, I have the right to examine and copy that information.

SECTION V. OTHER SPECIFIED ENTITIES AUTHORIZED TO SHARE INFORMATION

The entities listed below are additionally authorized to release, disclose, use, receive and/or exchange Protected Health Information under this Universal Release Form.

Entity Name	Address
1.	
2.	
3.	
4.	
5.	

SECTION VI. AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

CLIENT OR CLIENT'S LEGAL REPRESENTATIVE

_____
Printed Name

_____ _____/_____/_____
Signature Month Day Year

If signed by Client's Legal Representative, state relationship and authority to do so:
_____
_____
_____

WITNESS

_____ _____
Printed Name Agency Name

_____ _____
Agency Address Phone Number

_____ _____/_____/_____
Signature Month Day Year

REVOCATION OF AUTHORIZATION

I wish to revoke my authorization, effective as of the date below.

CLIENT OR CLIENT'S LEGAL REPRESENTATIVE

_____
Printed Name

_____ _____/_____/_____
Signature Month Day Year

WITNESS

_____ _____
Printed Name Agency Name

_____ _____
Agency Address Phone Number

_____ _____/_____/_____
Signature Month Day Year

SPECIFIC REVOCATION OF AUTHORIZATION OF SECTION II

I wish to revoke my authorization, effective as of the date below.

CLIENT OR CLIENT'S LEGAL COUNSEL

_____
Printed Name

_____ _____/_____/_____
Signature Month Day Year

WITNESS

_____ _____
Printed Name Agency Name

_____ _____
Agency Address Phone Number

_____ _____/_____/_____
Signature Month Day Year