

**AUTHORIZATION TO RELEASE PROTECTED HEALTH
INFORMATION TO ANOTHER ENTITY**

I hereby authorize: Specific Person _____
AR Psychiatric and Counseling Center
3312 D North OAK St., Ext.
Valdosta, GA 31605
Tel Number: (229) 244-2030 Fax Number (229) 244-2038

To release to: Facility Name _____
Provider Name _____
Street Address _____
City, State, Zip _____
Tel Number _____ Fax Number _____

My medical and mental health information obtained during the course of treatment of the below named individual:

Patient Name _____ **Date Of Birth** _____

DISCLOSURE OF RECORDS SHALL BE LIMITED TO THE FOLLOWING:

Psychiatric Evaluation _____ M.D. Evaluation & Notes _____ Test Results _____
Psychotherapy Notes _____ Treatment Plan _____ Dates of Service Only _____
Diagnosis _____ ALL Medical Records _____ Admission & Discharge Summary _____
Other (Please Specify) _____

THE DISCLOSURE OF RECORDS IS REQUIRED FOR THE FOLLOWING PURPOSE:

For ongoing treatment _____ **Other Purpose** _____

I understand that this release is binding, but I may revoke this authorization at any time except to the extent that action has been taken. Authorization will automatically expire one year from the date of my signature on ___/___/___ unless I revoke this authorization in writing sooner. I understand that the specific type of information to be disclosed may include history of drug, alcohol and/or psychiatric or mental health treatment, HIV/AIDS whose confidentiality is protected by Federal Law. Federal Law (42CFR, part 2) prohibits redisclosure of this information by the recipient. Minor patients, 12-17 years of age, and the parent or legal guardian must sign the authorization.

A photocopy or facsimile transmission of this authorization may be accepted in lieu of the original.

_____/_____/_____
(Signature of Parent or Guardian (12-17) _____ (Date) _____

_____/_____/_____
(Signature of Patient) _____ (Date) _____

_____/_____/_____
(Witness) _____ (Date) _____