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_____

StreetAddress_____

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)*