AUTHORIZATION TO REQUEST PROTECTED HEALTH INFORMATION FROM ANOTHER ENTITY

I hereby authorize: _____ **(Facility Name)**
_____ **(Provider Name)**
_____ **(Street Address)**
_____ **(City, State, Zip)**

To release to: _____ **(Specific Person)**
Valdosta Psychiatric Associates, LLC **(Name of Facility)**
3541 North Crossing Cir **(Street Address)**
Valdosta, GA 31602 **(City, State, Zip)**
(229) 244-4200 phone – (229) 244-4995 **(Telephone/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	☐ Diagnosis
☐ Dates of Service Only	☐ **ALL** Medical Records	☐ Admission & Discharge Summary

Other (Please Specify)
_____
_____

THE DISCLOSURE OF RECORDS IS REQUIRED FOR THE FOLLOWING PURPOSE:
For ongoing treatment

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)*