# AUTHORIZATION TO RELEASE PSYCHOTHERAPY/PSYCHIATRIC INFORMATION TO ANOTHER ENTITY

**I hereby authorize:** _Valdosta Psychiatric Associates, LLC_____**(Facility Name)**
_____ **(Provider Name)**
___3541 North Crossing Circle_____ **(Street Address)**
___Valdosta, GA 31602_____ **(City, State, Zip)**

**To release to:** _____ **(Specific Person)**
_____ **(Name of Facility)**
_____ **(Street Address)**
_____ **(City, State, Zip)**
_____ **(Telephone/Fax Number)**

My psychotherapy notes obtained during the course of treatment of the below named individual:

_____ **(Patient Name)**
_____ **(Date of Birth)**

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**DISCLOSURE OF RECORDS SHALL BE LIMITED TO THE FOLLOWING: (Check all that apply)**

☐ 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)
_____

For the Purpose of:_____

**THE DISCLOSURE OF RECORDS IS REQUIRED FOR THE FOLLOWING PURPOSE:**
*(Must be filled out)*

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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. I understand this authorization is voluntary, and Valdosta Psychiatric Associates will not condition my treatment on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) services are provided to me solely for the purpose of creating the protected health information to a third party.

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)*