120 East Trinity Place • Decatur, GA 30030 Phone (404) 378-2300 • Fax (404) 378-2394

AUTHORIZATION TO RELEASE/RECEIVE INFORMATION

CLIENT INFORMATION *(Confirm correct name spelling and DOB with client and/or guardian.)*			
First Name:	Middle Initial:	Last Name:	DOB:

This document authorizes Pathways Transition Programs, Inc. (PTP) to release and/or receive in writing or through telephone contact psychological, psychiatric, and general medical records including substance misuse or addiction information. Information will be shared, following Georgia State Statues and Federal Administrative Rules and Regulations, with:

INDIVIDUAL OR AGENCY	
Name:	
Address:	Phone:
Email Address:	Fax:

MEDICAL RECORD		
Information to be:	**RELEASED**	**RECEIVED**
	☐ All	☐ All
	☐ Medical Histories & Physicals	☐ Medical Histories & Physicals
	☐ Drug Screen Results	☐ Drug Screen Results
	☐ Assessments	☐ Assessments
	☐ Psychological Testing	☐ Psychological Testing
	☐ Psychiatric Testing	☐ Psychiatric Testing
	☐ Case Summary	☐ Case Summary
	☐ Discharge Summary	☐ Discharge Summary
	☐ Progress Notes	☐ Progress Notes
	☐ Treatment Plan	☐ Treatment Plan
	☐ Billing Information	☐ School Records
	☐ Other:	☐ Other:

PURPOSE OF RELEASE?			
Records released for?	Continued Treatment ☐	Case Planning ☐	Other:

RELEASE DURATION			
Records released for how long?	One Time ☐	One Year ☐	Continuous until:

If this release is for court ordered psychological evaluation, the evaluation will be used as evidence in court. It will be released to the referring agency or attorney; you may request information from that agency or attorney. Your consent can be withdrawn at any time, but we cannot recall information we have already shared in order to comply with your consent.

Redistribution of Confidential Information is Prohibited

Disclosed information is protected by Federal Rules governing confidentiality rules (42 CFR part 2). The Federal Rules prohibit recipients from making any further disclosure of this information unless the subject of the material provides additional written permission (42 CFR Part 2). This general authorization for the release of medical or other information is not sufficient for this purpose. Also, Federal Rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.

First Name:	Middle Initial:	Last Name:	DOB:

I am an adult, over 18 years of age; I am the client		☐	
The client is a minor; I am the client's parent		☐	
The client is a minor; I am the client's legal guardian		☐	
Other		☐ Please explain:	
Identification	Type	ID #	Exp Date: ☐ Date N/A

I understand all information contained in this document. I had the opportunity to ask questions and they have been answered.

I voluntarily authorize the information specified above to be obtained from or released to PTP; it will be held in strict confidence. I understand my information cannot be re-released by a recipient without my written consent. I understand this authorization will remain in effect until I specify an expiration date. If I have questions concerning any of this content in the future, I will ask my clinician.

I release PTP from any legal responsibility that may arise from the release of the above requested information.

Client/Parent/Guardian Signature	**Print Name**	**Date**

PTP Representative Signature & Credentials	**Print Name & Title**	**Date**