GEORGIA DEPARTMENT OF CORRECTIONS Facility: _____

MENTAL HEALTH SERVICES Name: _____

AUTHORIZATION FOR RELEASE ID #:_____

OF INFORMATION Race: _____ Sex: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby request and authorize: _____ (Name of Person/Agency)

_____
(Address)

to release the following type(s) of information from my records (and any specific portion thereof):

[ ] Dates of Hospitalization	[ ] History	[ ] Treatment Record
[ ] Academic Record	[ ] Discharge Summary	[ ] Physical Exam
[ ] Psychological Report	[ ] Psychiatric Report	[ ] Other

Release information to: _____ (Name of Person/Agency)

_____
(Address)

for the purpose of _____

All information I hereby authorize to be obtained will be held strictly confidential and cannot be released by the recipient without my written consent. I understand that this authorization will remain in effect for ninety (90) days unless I specify an earlier expiration date here: _____.

I understand that unless otherwise limited by state or federal regulation, and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time.

SIGN BELOW FOR GENERAL CONSENT TO RELEASE INFORMATION

PLEASE NOTE: Two witnesses are required if patient signs by a mark (X). One witness is required for all other signatures.

_____	_____	_____	_____
Signature of Witness (Title/Relationship)	Date	Signature of Offender/Client/Patient	Date
_____	_____	_____	_____
Signature of Witness (Title/Relationship)	Date	Signature of Parent/Auth. Representative (where applicable)	Date

IMPORTANT: Please sign below for release of the following specific information.

I, _____, consent to the release of confidential alcohol and drug information.

I,_____, consent to the release of confidential information concerning the testing for HIV (Human Immunodeficiency Virus) and/or treatment for AIDS (Acquired Immune Deficiency Syndrome) and related conditions.

USE THIS SPACE ONLY IF OFFENDER/CLIENT/PATIENT WITHDRAWS CONSENT

_____ _____
(Date this consent is revoked by Offender/client/patient) Signature of Offender/client/patient

Retention Schedule: Upon completion, the original form shall be given to the person/agency from whom records are being requested. A copy shall be placed in the offender's mental health file (section 5). At the end of the offender's need for mental health services and/or sentence, the mental health file shall be placed within the offender's health record and retained for 10 years.