Pathways
Transition Programs, Inc.

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

AUTHORIZATION TO RELEASE/RECEIVE INFORMATION

FILE NAME:	DATE:

REGARDING (NAME):			
First Name:	Middle Name:	Last Name:	DOB:

This will authorize **Pathways Transition Programs, Inc.** to release/receive, in writing or through telephone contact, general medical, psychological/psychiatric information including alcohol/drug abuse or addiction from my records in accordance with Georgia's Statutes and the State of Georgia and Federal Administrative Rules and Regulations to/from:

Name (Individual/Agency):		
Address:	Phone:	Fax:

INFORMATION TO BE: ☐ **RELEASED** ☐ **RECEIVED IS AS FOLLOWS:**

☐ Medical Histories and Physicals ☐ Reports from Psychological Testing ☐ Progress Notes
☐ Results from Drug Screens ☐ School Records ☐ Treatment Plan
☐ Assessment Report ☐ Closing Summary ☐ Other _____

PURPOSE OF RELEASE: ☐ Continued Treatment ☐ Case Planning ☐ Other _____

RELEASE DURATION: ☐ One Time ☐ Continuous For One Year

All information I hereby authorize to be obtained from or released to this agency 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 unless I specify an expiration date.

If this release is for court ordered psychological evaluation, it is understood that the report will be used as evidence in court. The psychological evaluation report will be released to the referring agency/attorney and you may request information from that agency or attorney. It is understood that this consent is subject to revocation at any time by the undersigned except to the extent that action has already been taken in compliance with this consent.

Notice of Prohibition on Redisclosure: This information has been disclosed to you from records protected by Federal Rules governing confidentiality rules (42 CFR part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I hereby release Pathways Transition Programs, Inc. from all legal responsibility that may arise from the release of the above requested information. This authorization is fully understood and it is made voluntarily and with informed consent on my part.

_____	_____	_____		_____
Client Signature (if adult)	**Print First Name**	**Print Last Name**		**Date**
_____	_____	_____	_____	_____
Legal Guardian's Signature	**Print First Name**	**Print Last Name**	**Relationship**	**Date**
_____	_____	_____	_____	_____
Pathway Staff Signature & Credentials	**Print First Name**	**Print Last Name**	**Title**	**Date**