

**GEORGIA DEPARTMENT OF CORRECTIONS**  
**MENTAL HEALTH SERVICES**  
**AUTHORIZATION FOR RELEASE**  
**OF INFORMATION**

Facility: \_\_\_\_\_  
Name: \_\_\_\_\_  
ID #: \_\_\_\_\_  
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):

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Dates of Hospitalization | <input type="checkbox"/> History            | <input type="checkbox"/> Treatment Record |
| <input type="checkbox"/> Academic Record          | <input type="checkbox"/> Discharge Summary  | <input type="checkbox"/> Physical Exam    |
| <input type="checkbox"/> Psychological Report     | <input type="checkbox"/> Psychiatric Report | <input type="checkbox"/> 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
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_____ Signature of Witness (Title/Relationship)	_____ Date	_____ Signature of Parent/Auth. Representative (where applicable)	_____ Date
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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