T V C

Therapy Center Valdosta

1811 B Green Circle, Valdosta, GA 31602 (229) 244-9688 fax (229) 244-5354

Patient: _____ SS#_____

Date of Birth: _____

I hereby authorize Therapy Center Valdosta to ( ) release ( ) receive information from:

Information to be released ( ) to ( ) from _____

The following information is to be released: _____

Information is needed for follow up of care.

If information is to be released to TCV, please fax to (229) 244-5354.

I understand that information in my health record may include information relation to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. Federal law prohibits the re-disclosure of the above information without written consent of the patient or authorized representative.

I understand that I have a right to revoke this authorization at any time by presenting a written revocation to the Medical Records Director or designee. I understand that the revocation will not apply to any information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless others revoked, this authorization will expire on the following date, event or condition: _____ if I fail to specify an expiration date, event or condition, this authorization will expire 90 days from the date above.

I understand that authorizing the disclosure of this health information is voluntary, and I need no sign this form in order to assure treatment.

I understand that any disclosure of information has the potential for an unauthorized redisclosure and that the re-disclosure may not be protected by federal confidentiality rules.

Date: _____

Name of Parent/ Guardian: _____

Signature: _____

Witness: _____