TIFTAREA
PSYCHIATRIC AND COUNSELING SERVICES, LLC
223 East Second Street, Suite B – Post Office Box 1613 – Tifton, Georgia 31793
(229) 339-3721 – www.TiftareaPACS.com – info@tiftareapacs.com

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Name: _____

Date of Birth: _____ Social Security #_____

TPACS is authorized to ___disclose to and/or ___obtain from:

Name: _____ Phone No: _____
Address: _____
Relationship: _____

(Check all that apply)

	Discharge Summary		Psychological Evaluation		Aftercare Plan
	Psychiatric Testing		Verbal Information/Patient Progress		Follow-up
	Treatment Plan		History/Physical		Family Information

Other: (specify) _____

For the following purpose: (check all that apply)

	Aid in Treatment		Discharge Planning		Legal Matters
	Family Involvement		Follow-up		
	School Involvement		EAP referral		

Other: (specify) _____

Send family program packet and questionnaire (where applicable)

I understand these records may contain information concerning sexually transmitted disease(s), acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), drug abuse, substance abuse, alcoholism, sickle cell anemia, and behavior or mental health services.

I understand that this authorization, except for action already taken, may be revoked by me at any time. I understand that if I revoke this authorization, I must do so in writing and

present my written revocation to TPACS. Unless otherwise revoked, this authorization will expire one year from today's date and must postdate any date of service being requested

This authorization becomes null and void from the date entered in the chart that the chart will be closed.

I understand that TPACS will not condition treatment, payment, enrollment, or eligibility for benefits concerning my health care on whether I sign or refuse to sign this authorization.

I understand that authorizing the disclosure of this health information is voluntary and that disclosure of such information carries with it the potential for unauthorized re-disclosure.

_____

Signature of Client/Guardian/Legal Representative Date Signed

_____

Print Name of Signee Relationship to Client Signature of Witness Date Signed

Copy of this authorization given to consumer YES/NO

Send Information to: _____

Request to revoke this authorization. YES/NO

_____ _____

Signature of Client/Representative/Staff Signature of Staff Witness

_____ _____

Date Date