Solutions Therapeutic Services

109 Central Ave.
Cartersville, GA 30120
(770) 383-8909
(770) 383-8930 – fax

AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Client or Guardian :_____
Minor Child's Name: _____
Client birth date(s) : _____
I HEREBY REQUEST AND AUTHORIZE:
Name/Agency: Solutions Therapeutic Service
_____(Therapist Name)
Address: 109 Central Ave. Cartersville, GA 30120
Phone: (770) 383-8909
Fax: (770) 383-8930
TO: ____ OBTAIN RECORDS FROM AND/OR _____RELEASE RECORDS TO:
Name/ Agency _____
Address: _____
_____
Phone: _____
To disclose the following specific information:
___ Psychiatric Evaluation ___ Psychological Reports ___ Medical Records
___ Psychosocial History ___ Treatment Plan ___ Labs (incl. Drug screen)
___ Case Records/Reports ___ Other _____

FOR THE PURPOSE OF:
_____

All information I hereby authorize to be obtained from this individual/agency will be held strictly confidential and cannot be released by the recipient without prior consent. I understand that unless otherwise limited by state or federal regulations and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time. If not previously revoked, this consent will terminate one year from the date appearing below.

_____ _____
Client/Legal Guardian Signature Date

_____ _____
Therapist Signature Date

Date Consent Revoked: _____ Signature:_____