PO BOX 2241, ELLIJAY GA 30540
706-635-5353

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, authorize _____

To disclose to or obtain from: _____ the copies of any and all records
NAME OF PERSON OR AGENCY
and information, which you may have in your possession. This includes all the transmission of information and data via verbal and electronic contact.

These records and information include, but may not be limited to:

- Hospital records, including that of attending nurses, physicians, healthcare personnel and technicians
- Laboratory test results
- Medical examination results
- Medical opinions, diagnosis, progress notes and recommendations
- Treatment plans and progress
- Description of treatment and prescriptions
- Notes of conversations, phone calls, memos or any type of communication concerning treatment

I understand the purpose of this disclosure is: _____

This authorization expires on: _____, or when Isaiah House is no longer providing me with services.

I understand that my records are protected under the federal regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it

PRINT CLIENT NAME _____DATE_____

SIGNATURE OF CLIENT _____

DATE OF BIRTH _____

PRINT WITNESS NAME _____DATE_____

WITNESS SIGATURE _____

Use This Space Only If Client Withdraws Consent

_____ _____

WITNESS/TITLE DATE SIGNATURE OF CLIENT