

Georgia Pines Community Service Board

Assisted Outpatient Treatment (AOT) Program

252 Woodlands Blvd. Thomasville, GA 31792

Mail: PO Box 1659, Thomasville, GA 31799

Office: (229) 225-5208 Ext. 331 | Fax: (229) 227-5447

Email: AOT@georgiapines.net

| | | |
|--|-----|---------|
| Name of Individual/Client/Consumer/Patient | | |
| SSN | DOB | Chart # |

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ hereby authorize the disclosure of the records/information indicated below both to and from the following agencies/entities/organizations for the purposes of participation in the Assisted Outpatient Treatment (AOT) Program. *This includes the disclosure of alcohol and drug abuse information.* My authorization is in compliance with a court ordered mandate for Outpatient Treatment services provided by Georgia Pines Community Service Board.

This Release of Information covers physical, electronic, and verbal transfer and/or disclosure of records.

- | | | |
|--|---|--|
| <input type="checkbox"/> Archbold Hospital/ED | <input type="checkbox"/> Archbold Northside | <input type="checkbox"/> Colquitt Reg Medical Center/ED |
| <input type="checkbox"/> Sterling Group Physicians | <input type="checkbox"/> Turning Point Care | <input type="checkbox"/> Greenleaf |
| <input type="checkbox"/> Mosaic | <input type="checkbox"/> The Heritage Foundation | <input type="checkbox"/> Aspire CSB |
| <input type="checkbox"/> Legacy CSB | <input type="checkbox"/> GA DBHDD | <input type="checkbox"/> Thomas County Law Enforcement |
| <input type="checkbox"/> Colquitt County Law Enforcement | <input type="checkbox"/> Grady County Law Enforcement | <input type="checkbox"/> Mitchell County Law Enforcement |
| <input type="checkbox"/> Thomas County Courts | <input type="checkbox"/> Colquitt County Courts | <input type="checkbox"/> State of Georgia Courts |
| <input type="checkbox"/> Georgia State Law Enforcement | <input type="checkbox"/> CRSA Probation | <input type="checkbox"/> Southwest Probation |
| <input type="checkbox"/> Georgia Dept of Public Health | <input type="checkbox"/> Georgia Dept of Corrections | <input type="checkbox"/> Georgia DFCS |
| <input type="checkbox"/> Georgia DCA | <input type="checkbox"/> AmericanWorks | <input type="checkbox"/> Social Security Administration |
| <input type="checkbox"/> OTHER (Specify): _____ | | |

Information Requested:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> History/Physical | <input type="checkbox"/> Aftercare Plan | <input type="checkbox"/> Assessments |
| <input type="checkbox"/> Family Information | <input type="checkbox"/> Medical Notes | <input type="checkbox"/> Medication Sheet | <input type="checkbox"/> Psychiatric Testing |
| <input type="checkbox"/> Lab Studies | <input type="checkbox"/> Treatment Plan | <input type="checkbox"/> Progress Notes | |
| <input type="checkbox"/> Other (Specify): _____ | | | |

Purpose/Need for Disclosure:

- | | | |
|--|--|---|
| <input type="checkbox"/> Legal Matters | <input type="checkbox"/> Aid in Treatment | <input type="checkbox"/> Planning Appropriate Treatment/Program |
| <input type="checkbox"/> Updating Files | <input type="checkbox"/> Case Review | <input type="checkbox"/> Maintain Family Involvement in Treatment |
| <input type="checkbox"/> Discharge Planning | <input type="checkbox"/> Payment of Bill | <input type="checkbox"/> Continuing Appropriate Treatment/Program |
| <input type="checkbox"/> Follow-up Care | <input type="checkbox"/> Insurance Claims | <input type="checkbox"/> Determining Eligibility for Benefits/Program |
| <input type="checkbox"/> Keep Referral Source Informed | <input type="checkbox"/> Maintain School Involvement | |
| <input type="checkbox"/> Other (Specify): _____ | | |

This authorization may be revoked by me in writing any time before the release date of the above information. This authorization will expire one year from the signature date unless another date is specified below. This release is limited to the person(s)/agencies/organization(s) named above and further release is prohibited without specific additional consent of the individual. I agree that the signed consent on this form may be used in electronic format using electronic or scanned signatures.

Date

Signature of Individual

Signature of Witness (Title or Relationship to Individual)

Signature of (check one): Date
 Parent Guardian Court-appointed Custodian of Minor
 Agent designated by Individual's Advance Directive

USE THIS SPACE ONLY IF AUTHORIZATION IS WITHDRAWN

Date this authorization is revoked by Individual

Signature of Individual or legally authorized representative.