Visions Soulutions Counseling Services
Release of Information

Individual's Name: _____ Date of Birth: _____

Social Security Number: _____ MR#: _____

The following medical information has been disclosed to you from records whose confidentiality is protected by Federal law (42 CFR. Part 2) which prohibit you from making any further disclosure of this without the specific consent of the person who it pertains to, or as otherwise by such regulations. Re-disclosure of this information is not permitted by law.

I, _____, hereby authorize:
(print name of person completing this form)

_____
(print name/agency of whom you are giving permission for Visions to contact)

Address of individual/agency:

_____

Phone: _____ Fax: _____ to release to or exchange with Visions Soulutions Counseling Services 224 N. Central Lane,Tifton, GA 31794 (229) 472-0189 (phone) and (229) 256-5558 (fax).

Information Requested

_____Social History
_____Psychiatric Exam and History
_____Psychological
_____Individualized Education Plan/School Records
_____Discharge Summary
_____Progress Notes
_____Physical/Medical Information
_____Educational Evaluation
_____No restrictions are placed on the information being released

Information is requested for the purpose of:

_____

I acknowledge this authorization is given voluntarily, with my informed consent, and is valid until this request is completed: _____ (please provide date or number of days- max of 365 days). By signing below, I acknowledge permission to obtain/release requested information. This authorization may be revoked at any time.

Individual's Signature: _____ **Date**: _____

Parent/AR Signature: _____ **Date**: _____

Visions Representative: _____ **Date**: _____