

WAIVER AND CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

HENRY COUNTY , Georgia RESOURCE COURT (HCRC)

I,, Social Security Number,			mber,,
Date of Birth,		Case Number,	, hereby request and
authorize the Henry County Res	source Court (HCRO	C) to obtain records from the fo	ollowing agencies:
NCLUDES ALL – DO NOT CID Henry County Jail – Correct Head Henry County Health Departmen Henry Medical Ctr. & Piedmont I Henry County School System Social Security Administration Worktech Georgia Department of Labor Riverwoods Veterans Administration The information so obtained will be coordinating treatment services; (bushless of the court of court of the court of t	RCLE – ADD OTHE th t Henry Hosp. S C C De used by the Henry D) providing referral is diagnosis, treatment i	ER PARTIES NOT INCLUDED McIntosh Trail Community Service Pine Woods Crisis Stabilization Undenry County Department of Familia Southern Regional Hospital Clayton Center GA Division of Behavioral Health Southern Crescent Behavioral Hea County Henry County Resource information; and (c) monitoring cossues, participation in treatment,	and Developmental Disabilities lth Systems Court (HCRC) for the purposes of (a) compliance with the treatment program, attendance, progress,
prognosis and completion of treatn			
 Dates of Hospitalization Discharge Summary Medical History Diagnosis Lab Reports Hepatitis History 	 Psychiatric Evaluat Psychological Reposition Social History Treatment Plan HIV/AIDS History Other: 	orts • Nursing Assessn • Correspondence • Administrative/L	nent Legal Documents
mental health, mental illness, mental information for court monitoring further consent to the release information below I hereby release which might arise from the release years following completion of the pe checked for five years following	ental retardation, and and case management mation for primary can the HCRC, its officer to of information author to HCRC program (or g my completion, with	d/or substance abuse information in services related to discharge per services related to diagnosis, treats, agents and employees from any orized above. I understand that the ompletion, withdrawal or dismissathdrawal or dismissal from HCRC	on released to HCRC which may include in. I hereby consent to the release of lanning and social services benefits. I eatment, evaluation and follow-up. I and all liabilities, damages, and claims is consent remains in effect until three all). I consent for my criminal history to a for the purpose of follow-up, research, written notification, but any information
and program evaluation. I unders released prior to the withdrawal of			ritten notification, but any information
IMPORTANT: I understand that the federal regulations governing (Insurance Portability Act of 1996)	my alcohol and/or tre Confidentiality of Alc (HIPPA), 45 C.F.R. F	eatment records and behavior healt cohol and Drug Abuse Patient Re Pts. 160 & 164, and cannot be disc	th treatment records are protected under cords, 42 C.F.R. Part 2, and the Health closed without my written authorization sed without my written authorization.
Print Name	Signatur	re of Defendant	Date
Print Name	 Signature	e of Attorney	

Please remit medical records to: Henry County Resource Court, 140 Henry Parkway, McDonough, GA 30253 Phone #: 770-288-7591 Fax #: 770-288-7594