Authorization for the Release and/or Discussion of Protected Information

	Name:	SS#:	Birth Date:
1.	______________________	_____________	__________________
2.	______________________	_____________	__________________
3.	______________________	_____________	__________________
4.	______________________	_____________	__________________
5.	______________________	_____________	__________________

AUTHORIZATION

I, ______________________ hereby consent to and authorize the release and/or discussion of the information outlined below concerning the individuals named above to and/or with Woodrow W. Ware III, Esq. Please provide such information to **WOODROW W. WARE III, ESQ., THE LAW OFFICES OF WOODROW WILSON WARE, LLC, 1551 JENNINGS MILL ROAD, SUITE 1800A, WATKINSVILLE, GEORGIA 30677.**

____ **Complete Record**, or select individually from the following:

___ *Emergency Room Records*
___ *Laboratory & Diagnostic Findings*
___ *Mental Health Treatment Information*
___ *Substance Abuse Treatment Information*
___ *Office-based Records*
___ *Billing/Insurance Information*
___ *Educational Records*
___ *Hospital/Clinic Outpatient Records*
___ *Hospital/Clinic Inpatient Records*
___ *Medicaid/DOH records*
___ *DFCS Records*
___ *Treatment Plan Update*
___ *HIV Testing or Treatment*

SIGNATURE

I have carefully read and understand the above information and herein consent to its disclosure. I am aware that information regarding medical conditions will be released to the person(s) or organization(s) named above. If the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws, I understand that subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

I understand that this consent is subject to revocation, in writing, at any time, unless action based on it has already begun. This authorization expires upon the completion of the Guardian ad Litem investigation in the above-referenced

I authorize the use of a copy of this form for the disclosure of the information described above.

Signed: ____
(Patient or Patient's Legally Authorized Representative)

Date: ______________________