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, 1720 EPPS BRIDGE PARKWAY, SUITE 108-349, ATHENS, GEORGIA 30606.**

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

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: _____