SOUTHERN PEAKS
REGIONAL TREATMENT CENTER

Abraxas
a GEO Group Company

Southern Peaks Regional Treatment Center

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

Youth's Name_____ DOB_____

Legal Guardian/Custodian_____ Date_____

I hereby authorize (Name of Agency/Professional): _____

_____

To Release information to: Southern Peaks Regional Treatment Center_____

Purpose: Continuity of Care / Medical follow-up_____

We are requesting the following information:

☐ Complete Psychological	☐ Personality Inventory	☐ Projective
☐ Neuropsychological	x Psychiatric Evaluation	☐ I.Q. Testing
x Medication Management	☐ Development History	x Dental
☐ Social History	☐ Neurological	☐ Visual
☐ Educational Reports	x Medical	☐ IEP
☐ Substance Abuse Evaluation	☐ Police Reports	☐ Court Record
☐ Probation Reports	☐ Treatment Progress	☐ Treatment
☐ Other_____		

I understand that my records are protected under the federal regulations governing Confidentiality of Patient Records, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time (in writing) except to the extent that action has already been taken in reliance on it, and that in any event, this consent expires automatically three months after my discharge from the Southern Peaks Regional Treatment Center.

_____ _____
Youth Signature Date

_____ _____
Legal Guardian/Legal Custodian Signature Date

_____ _____
Witness Signature Date

NOTICE TO RECIPIENT OF INFORMATION: Federal regulations prohibit you from making further disclosure without specific written consent of the person to whom it pertains, or as otherwise permitted b such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.