Oconee Center for Behavioral Health
1360 Caduceus Way Building 400, Suite 102,
Watkinsville, Georgia 30677
Ph: 706-286-8442 Fx: 706-310-6907

# Consent Form for Release/ Request of Information

Patient Name: _____

Date of Birth: _____ SSN: _____

Legal Guardian if Patient is a Minor: _____

I, _____, give my permission to the Providers, Faculty, and Staff of Oconee Center for Behavioral Health, LLC as well as the person(s) listed below to exchange information and/ or records regarding myself or my dependents. I give my permission for a faxed or photo copied signature to serve as an original regarding this release. The purpose of this release is to request/ release information for the benefit of the patient's diagnosis, treatment planning, continuity of care, family medical leave, disability requests and/ or benefit claims for life/ health insurance application. The information released pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by the privacy act. This authorization may be revoked by the individual signing this consent by providing written, signed and dated, request to withdraw the authorization except to the extent that the action has already been taken.

1.Name: _____

Phone #: _____ Fax #: _____

2.Name: _____

Phone #: _____ Fax #: _____

3.Name: _____

Phone #: _____ Fax #: _____

4.Name: _____

Phone #: _____ Fax #: _____

Printed Patient Name: _____

Signature: _____ Date: _____

Relationship to Patient: _____