Authorization for Release of Medical Information

Effective Date: _____

I _____ hereby give my consent to
(Parent or Guardian's name)

_____
(Doctor or last therapy clinic)

to release _____ Protected Health Information
(Patient's Name)

to Southern Therapy Solutions.

Information is needed regarding medical care received from _____ to _____
(Month/Year) (Month/Year)

Or for care received regarding (Diagnosis/Illness) _____

_____

Or list specific information to be released _____

_____

Please fax requested documentation to: 1-888-450-0379

Or mail to:

Southern Therapy Solutions
3256 North Valdosta Road
Valdosta, GA 31602

_____ _____
Signature of Parent or Guardian Date

Initial: ___