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Meg Schroeder, MS, ALC

CLIENT INFORMATION		In ac HIP	In accordance with Federal Regulations 42 CFR part 2 and HIPAA, I hereby authorize Wiregrass Behavioral Group, LCC		
NAME				obtain records from	
DOB			To	disclose and release records to	
Last 4			y (Offi	ice/Clinic/Hospital)	
SSN DATE					
	entity / individual / agency:				
NAME	entity / individual / agency.	ADD	RESS		
PHONE		ADE	KESS		
FAX					
	hereby authorized to be released:	I .			
	Psychiatric evaluation			Drug / Alcohol treatment	
	Progress notes			Lab results	
	Medication orders			Attendance	
	Treatment recommendations & plans			Psychological testing	
	Other (Specify):		•		
For the time	period of:	Pu	rpose	for disclosure:	
	All treatments			Comprehensive treatment	
	Previous 6 months			Family involvement	
	Previous 1 month			Aftercare / follow up / transition of care	
	Specific time period of :			Continuity of care	
	Other (Specify):			Legal issues	
Authorization	Other (Specify): 1 will automatically expire 1 year after the da	te of author	izatio	Legal issues Other : n, or date specified here:	
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