GEORGIA MENTAL HEALTH CONSUMER NETWORK

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Georgia Mental Health Consumer Network
Training Release Consent Form

Participant's Full Name: _____

Participant's Address: _____

City, State, Zip Code: _____

Phone Number: _____ Email Address:_____

Recipient of Training Records:

Name/Organization:_____

Address:_____

City, State, Zip Code:_____

Phone Number:_____ Email Address:_____

Purpose of Release:

The training records are being released for the following purpose(s):

_____

_____

Description of Records to be Released:

The following training records are authorized for release (please check all that apply):

☐ Attendance Records

☐ Certification/Completion Records

☐ Continuing Education Verification

Consent Statement:

I, _____, hereby authorize Georgia Mental Health Consumer Network to release the specified training records to _____for the purpose(s) stated above. I understand that this authorization is voluntary and that I may revoke this consent at any time by providing written notice to Georgia Mental Health Consumer Network. This consent is valid for 6 months or until revoked by me in writing. I also understand that a revocation will not affect any disclosures already made before the receipt of the revocation.

I acknowledge that I have received, read, and understand the contents of this form. I further acknowledge that a copy of this signed consent form will be provided to me for my records.

_____ _____

Signature of Participant: Date

_____ _____

Signature of Witness Date