AUTHORIZATION FOR THE TRANSFER AND/OR RELEASE OF ASSESSMENT RESULTS

SECTION 1: Student/Offender Information (Student/Offender must complete this Section)

Last Name *Suffix (Jr., Sr., III)*

First Name *Middle Name (if applicable)*

Date of Birth *Social Security Number (if applicable)*

SECTION 2: Transfer Type (Student/Offender must complete this Section)

I request that my Assessment results be transferred and/or released for the following reason:

☐ **Release/Transfer of Assessment results to a Clinical Evaluator**
☐ **Release/Transfer of Assessment results to another Risk Reduction Program**
☐ **Release/Transfer of Assessment results to a Court Official, Probation Officer, Employer**

SECTION 3: Transfer Information (Student/Offender or Program initiating transfer must complete this Section)

Name of Program Assessment results Released by/Transferred FROM:

Program Name *Certification No.*

Printed Name of Program Official *Signature of Program Official* *Date*

Student / Offender's Certificate of Completion # *Date of Completion*

Name of Program or Clinical Evaluator Assessment results Release or Transferring TO:

Program/Clinical Evaluator Name *Certification No.*

SECTION 4: This Section should only be completed by the Student/Offender if Assessment results are being released/transferred to someone other than a Risk Reduction Program or Clinical Evaluator (Court, Probation Officer, Employer, etc.)

Name of Person or Organization Receiving Assessment Results

SECTION 5: Transfer Reason

Reason for transfer of Assessment results to another Risk Reduction Program:

☐ **Course Cancellation** Ga. Admin. Comp. Ch. 375-5-6-.14(c)(1)
☐ **Student/Offender has moved +30 miles from where assessed** Ga. Admin. Comp. Ch. 375-5-6-.14(c)(2)
☐ **Program closure/Temporary Closure**
☐ **Documented Emergency (prior approval by the Department is required)** Ga. Admin. Comp. Ch. 375-5-6-.14(c)(3)

I do hereby authorize the above-referenced program to transfer and/or release my Needs Assessment results to the Program, Clinical Evaluator, or other person/organization named herein. I understand that I may be charged a fee of up to $25 to have my Assessment results transferred. I further understand that this release authorization shall remain valid for a period of 90 days and may be revoked at any time, if done so in writing.

Signature of Student/Offender *Date*

Name of DDS Official approving emergency transfer *Date*

IMPORTANT

(1) Prior approval by the Department is no longer required to transfer results EXCEPT in the case of a documented emergency.
(2) Emergency approval may be obtained by contacting 678-413-8745 between 8:00 a.m. and 4:00 p.m. Monday through Friday, excluding holidays.