

**GEORGIA DEPARTMENT OF
HUMAN RESOURCES**

**NOTICE OF DISCHARGE
UNDER TEMPORARY AND
IMMEDIATE CARE ACT**

CLIENT IDENTIFICATION

Name: _____

Address: _____

Telephone: _____

_____, 20 ____
Facility

_____ was or will be discharged on _____, 20 ____

under the provisions of 1986 Georgia Laws 1092; O.C.G.A. 37-4-40.2. The above-named client was or is to be discharged within 48 hours of being received, Saturdays, Sundays, and holidays excluded, at this facility.

For more information, contact _____ at _____
(Telephone)

	Date of Mailing or Notice	Signature of Staff
c: Client	_____	_____
Second Representative	_____	_____
Guardian Ad Litem (if applicable)	_____	_____
Physician or Psychologist Signing Certificate	_____	_____
Clinical Record	_____	_____