Atlanta Psychiatric Specialists, P.C.
Ross F. Grumet, M.D.
1718 Peachtree Street NW
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Dispensation

Fax: *Mail out:* *Pick up:*

Authorization for Release of Confidential Medical Information

Patient Name: ____ SSN:____

Date of Birth ____Patient Phone Number ____

Treatment dates to be released ____

Type of Visit Inpatient ________ Out Patient ________ ER ________ Lab _________ Therapy _________ Other _________

This information is to be: Released to ______ Received from _____ Authorization communication with ______

Name: ____ Attn: ____

Address ____

City, State, Zip ____

Phone Number ____

Fax Number ____

Purpose of Disclosure (check one)

____Insurance _____Personal
_____Legal _____ Continuing Care
_____ Other Specify _____________

Portions of Record needed – Check all that apply

_____ Psychiatric Evaluation
_____ Medication and dosages
_____ Laboratory Studies
_____ Physician Progress Notes
_____ Face Sheet
_____ Therapy Notes
_____ Psychological Evaluation
_____ Discharge Summaries
_____ Drug/Alcohol Test Results
_____ History and Physical
_____ Medical Reports
_____ Social History
_____ Hospital Records
_____ HIV testing/Information
_____ Consent Form (Condition of Treatment)

I hereby authorize Atlanta Psychiatric Specialists and / or Dr. Ross Grumet to release / disclose / receive medical records and / or other information obtained in the course of my diagnosis and treatment. I agree to pay copy charges if applicable for Legal, Insurance and / or Personal Use.

I hereby release Atlanta Psychiatric Specialists and / or Dr. Ross Grumet from any liability which may result from this disclosure of confidential medical information, or which may arise as a result of the use of the information contained in the information released. I understand that I may revoke this authorization by providing written notice of my intention. Unless withdrawn, this consent will expire 90 days from the date signed.

_____ This information may include Medical / Surgical, Psychiatric, Substance Abuse, and HIV / AIDS information.
_____ I authorize that this information may be faxed to the requesting Health Care Provider.

Patient's Signature: ____ Date: ____

Patient's Representative: ____ Date: ____

Authority to sign on behalf of this patient is authorized by ____

Witness By: ____

Please Note: Records requested for continued care will be mailed / faxed directly to the Doctor / Health Care Provider.