Atlanta Psychiatric Specialists, PC
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Atlanta, GA 30309
(T) 404-685-9414 **(F)** 404-685-9420

AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS

Please complete this form in its entirety.

Patient Name: _____ **DOB:** _____

Patient Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone (if we need to reach you regarding this request): _____

The purpose of this release is for:
□ Continuation of care □ Legal □ Disability □ Other: _____

This release authorizes **Atlanta Psychiatric Specialists, PC to (check one):**

□ Disclose information to individual or entity named below
□ Receive information from individual or entity named below
□ Authorize communication with an individual or entity named below

Name of authorized individual or entity: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone :_____ Fax: _____

Specific information to be disclosed (check all applicable items to be released)
□ Progress notes
□ Medication records
□ Lab reports
□ Intake summary
□ Discharge summary
□ Other (please specify): _____

To protect your privacy, state and Federal regulations have placed additional restrictions on the release of records relating to the diagnosis and treatment of mental health conditions, substance use conditions, and HIV/AIDS. We are required to have specific consent from you to disclose these portions of your medical records (if applicable). If you agree to this disclosure, please sign below:

□ Mental health records **Initial:** _____

□ Treatment for substance use **Initial:** _____

□ HIV/AIDS diagnosis or treatment **Initial:** _____

_____ _____
(Signature of Patient or Authorized Representative) (Date)

_____ _____
(Relationship to patient if not self) (Date)