

Atlanta Psychiatric Specialists, P.C.

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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

- | | | |
|---|--|--|
| <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Therapy Notes | <input type="checkbox"/> Medical Reports |
| <input type="checkbox"/> Medication and dosages | <input type="checkbox"/> Psychological Evaluation | <input type="checkbox"/> Social History |
| <input type="checkbox"/> Laboratory Studies | <input type="checkbox"/> Discharge Summaries | <input type="checkbox"/> Hospital Records |
| <input type="checkbox"/> Physician Progress Notes | <input type="checkbox"/> Drug/Alcohol Test Results | <input type="checkbox"/> HIV testing/Information |
| <input type="checkbox"/> Face Sheet | <input type="checkbox"/> History and Physical | <input type="checkbox"/> 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 Unless withdrawn, this consent will expire 90 days from the date signed.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.