# Atlanta Psychiatric Medicine Inc.

*"Psychiatric care for all ages"*

## Release of Health Information

I, _____ DOB_____

(Patient First & Last Name)

Hereby authorize Atlanta Psychiatric Medicine Inc. to release/request (circle one) the following information and records obtained in the course of my diagnosis and treatment. I understand that these records may contain confidential information.

Please circle as many as apply

- Medical Records
- Lab Results
- Psychiatric Assessment and Diagnosis
- Medication Management Information
- Other (please specify)

Information is to be released to / requested from (circle one or both)

| Name of Individual/Organization | Address | Phone/Fax Number |
|---|---|---|
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |
| 3. _____ | _____ | _____ |

I understand that I have the right to revoke this authorization at any time and that cancellation or modification of this authorization must be provided by me in writing and received by Atlanta Psychiatric Medicine Inc. in order to be effective. I understand that any use or disclosure/request made prior to the revocation of this authorization will not be affected by the revocation. I understand that I have the right to refuse consent and singing of this authorization and that my treatment or the treatment of those under my guardianship shall not be affected. I understand that I am voluntarily signing this to release/request my health information to the party or parties designated. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable state laws may protect such information This authorization is effective immediately and shall remain in effect for one year from the date of signing unless explicitly revoked in writing.

Signature: _____ Date: _____

(patient, parent, or legal guardian)

Relationship to Patient: _____

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