Benjamin Akosa M.D.
Vin Nagaraj M.D.
Ana Segarra-Brechtel M.D.
Heerain Shah M.D.

Your Journey to Wellness

ANNUAL CONSENT

Patient Name: ____DOB: ____/____/______

Consent to Release Medical Information to a Spouse, Family Member or Significant Other:

I **DO** authorize information to be released to the following:

Tell us with whom we may discuss your protected health information:

1.____________________________________ Relation:_______________________

Phone or email:____

2.____________________________________ Relation:_______________________

Phone or email:____

3.____________________________________ Relation:_______________________

Phone or email:____

I **DO NOT** authorize information to be released to anyone but myself.

Signature: ________________________________**Date____/____/____**

Print Name: ____

Email: ____

Annual Consent- March 3, 2022

1325 Satellite Blvd NW • Bldg 400 • Suwanee, GA 30024 • Phone 678.263.3080 • Fax 678.496.9863
Psychiatry@PsychiatricProfessionals.com • www.PsychiatricProfessionals.com