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Your Journey to Wellness

Release of Information/Medical Records Release

I,___________________________________, hereby authorize Psychiatric Professionals of Georgia to release

information from the records of ________________________________DOB:____________________, for the purpose/s of:

1. Psychiatric Evaluation ______
2. Medication Evaluation ______
3. Ongoing Treatment ______
4. Insurance Request/Claims ______

The information I wish to be released includes all or some of the following:

_____Progress reports or visit notes
_____Financial records
_____Prescription history
_____Diagnosis

Release/send information to:

Name____

Address____

Telephone and Fax____

Authorization to remain in effect for:

Specific date range_________________________________
All prior dates from _________________________________

I understand that in order to protect confidentiality, my agreement to obtain and/or release information is necessary and this permission is limited for the purposes and to the person listed above. I also understand that unless otherwise limited by state or federal regulations (such as court mandate) I can cancel this consent at any time, except for action, which has already been taken.

Signature of Patient or Parent/Legal Guardian____

Date____________________________________

ROI: March 3, 2022