▪ 6025 Professional Parkway,
Suite 301, Douglasville, GA 30134

▪ 1314 Concord Road SE,
Smyrna, GA 30080

770-438-1799
GPS@mindandsleep.com
770-825-9046
www.mindandsleep.com

Release of Medical Information

This form serves as an authorization for use or disclosure of your protected health information. *Please complete all sections.*

I. IDENTIFICATION

I, ________________________________ *DOB*: ______________ hereby voluntarily authorize the disclosure of information from my mental health record.

The information is to be disclosed by:		*And is to be provided to:*
Name of Facility/Provider		Name of Facility/Provider
Address		Address
Phone		Phone
Fax		Fax
Email		Email

II. PURPOSE

The purpose of this disclosure is:

☐ Further Medical/Mental Health Care ☐ Attorney ☐ School ☐ Research
☐ Personal Use ☐ Insurance ☐ Disability ☐ Other: ______________________________

III. THE INFORMATION TO BE DISCLOSED FROM MY MENTAL HEALTH RECORD

Disclosed information will occur in a two-way capacity, allowing for verbal, electronic, or written communication between the above named people/organizations/agencies/facilities

☐ Only information related to: ____________________________________
☐ Only the period of events from ________________ to _______________
☐ Entire Record
☐ Summary Letter/Note about treatment (including presenting problem, goals, treatment & outcome)
☐ Other: ____

IV. SIGNATURE AND UNDERSTANDING

I understand that I may revoke this authorization in writing submitted at any time to Georgia Psychiatry & Sleep, except to the extent that action has been taken in reliance on this authorization. If authorization has not been revoked, it will continue unless an updated release is provided.
Medical records frequently contain information which may be privileged and/or confidential remarks furnished by the patient, patient's family and staff. If, in the judgment of the medical staff, disclosure of the privileged/confidential information will be harmful to the patient, release of such information may be withheld in accordance with specific state and federal regulations. Records released may contain alcohol and drug treatment information, AIDS/HIV, psychiatrics/psychological/other mental health privileged or confidential information. Certain communications are privileged and not subject to release without your consent under state and/or federal law.
After giving due consideration to the above statement, I authorize Georgia Psychiatry & Sleep and/or members of its staff to furnish information, including verbal and/or written communication, photocopy or faxed copies of my medical record, including matters privileged under the laws of the state of Georgia, and applicable federal laws and regulations, to the above organization or to its agent. I further agree to indemnify and hold harmless Georgia Psychiatry & Sleep and staff from all liability that may arise from the release of the information herein requested.

____ ____
Patient Name **Guardian Name (if applicable)**

____ ______________________________
Patient / Guardian Signature **Date**