

▪ 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(Sender):

And is to be provided to:(receiver)

Name of Facility/Provider	➡	Name of Facility/Provider
Address	↔	Address
Phone		Phone
Fax		Fax
Email		Email

II. PURPOSE

The purpose of this disclosure is:

- | | | | |
|---|------------------------------------|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> Further Medical/Mental Health Care | <input type="checkbox"/> Attorney | <input type="checkbox"/> School | <input type="checkbox"/> Research |
| <input type="checkbox"/> Personal Use | <input type="checkbox"/> Insurance | <input type="checkbox"/> Disability | <input type="checkbox"/> 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 If authorization has not been revoked, it will continue unless an updated release is provided.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)

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Patient / Guardian Signature

Date