Psychiatric Professionals of GEORGIA

Your Journey to Wellness

Authorization to Obtain and/or Release Information

I,_____, hereby authorize Psychiatric Professionals of Georgia to release and/or obtain 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 to be released and/or obtained includes all or some of the following:

1. Psychiatric Evaluation, Progress Notes, Course of Treatment, Medication History, Psychosocial History, Hospitalization Course, Discharge Summary
2. Psychological Testing Reports
3. Medical/Surgical Records
4. School Records
5. Lab/Imaging Reports
6. Juvenile Court Records
7. Other social agency reports

Release/Obtain information to/from:

Name_____

Address_____

Telephone and Fax_____

PLEASE FORWARD INFORMATION TO THE ATTENTION OF PSYCHIATRIC PROFESSIONALS OF GEORGIA.

Authorization will remain in effect for:

_____ One year or until and earlier date specified here: Date_____
_____ The time necessary to complete my treatment
_____ Duration of court mandate: Date_____

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_____

Signature of Provider_____

Date_____

1490 Distribution Drive • Suite 150 • Suwanee, GA 30024 • Phone 678.263.3080 • Fax 678.496.9863
Psychiatry@PsychProsGA.com • www.PsychProsGA.com