Georgia Psychiatry & Sleep
4015 South Cobb Dr ◆ Suite 220 ◆ Smyrna, GA 30080
Tel: 770.438.1799◆ Fax: 770.825.9046◆

Authorization to Release Information

Patient:_______________________________ DOB_____________________
I hereby request and authorize Georgia Psychiatry & Sleep to release and receive my medical records/information to:

Name: ____

Address: ____
Fax:____

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 the Georgia Psychiatry & Sleep and/or members of its staff to furnish information, including verbal 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 staff from all liability that may arise from the release of the information herein requested.

___________________________ ____
Date signed Patient/Parents/Legal Guardian's Signature

Effective: February 2012