peachtree DBT

peachtree psychiatric professionals, p.c.

3520 PIEDMONT RD, NE
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ATLANTA, GA 30305

PHONE 404 351 2008
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Medical Release of Information

Patient Name: _____ **Date of Birth:** _____

I hereby consent to the release of my protected health information (*please fill in the appropriate section*):

From:

Peachtree Psychiatric Professionals, P.C.
3520 Piedmont Rd NE, Suite 350
Atlanta, GA 30305
Phone: 404-351-2008
Fax: 404-809-3321

To:

Name _____
Address _____
_____
_____
Phone _____
Fax _____

From:

Name _____
Address _____
_____
_____
Phone _____
Fax _____

To:

Peachtree Psychiatric Professionals, P.C.
3520 Piedmont Rd NE, Suite 350
Atlanta, GA 30305
Phone: 404-351-2008
Fax: 404-809-3321

Data shall include:

[ ] Ongoing Communication between parties above
[ ] Ongoing Communication Regarding Billing Information, Appointments, and Medication
[ ] Discharge Note with Summary
[ ] Other: _____

[ ] Initial Assessment
[ ] Progress Notes
[ ] Medication Record
[ ] Treatment Summary
[ ] All of the above

Specific purpose: [ ] Continued/Coordinated care [ ] Other, please specify:_____

I understand that *if the aforementioned records pertain to drug or alcohol abuse treatment, HIV/AIDS testing, treatment or related illness that such information will be released pursuant to this authorization form.* ***I understand and agree that:*** *1) I have a right to inspect my Protected Health Information; 2) I may revoke this authorization in writing at any time; 3) Peachtree Psychiatric Professionals, P.C. may disclose my PHI without my consent only in specific circumstances authorized by law; and 4) my treatment provider may refuse to disclose or allow my inspection of part or all of my PHI if he/she believes that is necessary to protect me or someone else from psychological or other harm.*

This consent form has been explained to me and I understand the contents to be released, the need for the information, and that there are statues and regulations protecting the confidentiality of authorized information. I hereby acknowledge that this consent is truly voluntary and is valid until such request is fulfilled. Any revocation of this consent will not apply to information that has previously been released in accordance with this consent.

Signature: _____ **Date:** _____
(Patient or Legal Guardian)

Witness:_____ **Date:** _____