Atlanta Psychiatry & Neurology, P.C.
d/b/a Atlanta Behavioral care

3188 Atlanta Road S.E. Smyrna, GA 30080-8256
Office Number (770)319-6000 Fax Number (770)319-6330

CONSENT TO RELEASE/RECEIVE CONFIDENTIAL INFORMATION

I_____, Date of Birth: ____/____/____ authorize Atlanta Psychiatry & Neurology P.C. d/b/a Atlanta Behavioral Care, at the above address to:

CHECK ALL THAT APPLY:

☐ Receive my medical history information **from** the following physician/healthcare provider:

Name/Address_____

_____Fax Number:_____

☐ Release my treatment information/records **to** the following physician/healthcare provider:

Name/Address_____

_____Fax Number:_____

☐ Release my treatment information **to** the health insurance company/employer listed below for billing disability reporting purposes:

Name/Address_____

_____Fax Number:_____

Information to be released:

☐ **Complete Record** ☐ **Progress Notes Only** ☐ **Labs** ☐ **Other_____**

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken in reliance on it. This consent will expire 365 days after I complete my treatment, unless the physician specified above is other notified by me.

I understand that the records to be released may contain information pertaining to the psychiatric treatment and/or treatment for alcohol and/or drug dependence. These records may also contain confidential information about communicable diseases including HIV (AIDS) or related illness. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits the recipient of these records from making any further disclosures to third parties without the express written consent of the patient.

I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment information/records under 42 CFR Part 2, and I further acknowledge that I understand those rights.

_____ _____
Patient Signature Date

_____ _____ _____
Parent/Guardian Signature Parent/Guardian Name (Print) Date

_____ _____ _____
Witness Signature Witness Name (Print) Date