

Atlanta Area Psychological Associates, P.C.

Consent to Release Confidential Information

There is a \$45 fee for the release of records, payable in advance.

Requests for records that are dated for the current and past calendar years will be processed within 30 days.

Requests for records that are dated prior to the previous calendar year may take up to 90 days process.

I, _____, hereby authorize an exchange of confidential medical information regarding _____ between the following persons or agencies:

1. Atlanta Area Psych. Assoc. 2. _____ 3. _____
2520 Windy Hill Rd #203 _____ _____
Marietta, Ga 30067 _____ _____
(770) 953-6401 _____ _____

Information may be exchanged from:

1 to 2 2 to 1 1 to 3 3 to 1 2 to 3 3 to 2 between all

The following items may be copied and or provided:

- | | | |
|--|--|--|
| <input type="checkbox"/> Treatment Attendance | <input type="checkbox"/> Level of Participation | <input type="checkbox"/> Treatment Plan |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> History and Physical Exam | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Psychiatric Reports | <input type="checkbox"/> Psychological Reports | <input type="checkbox"/> Consultation Report |
| <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Medical Reports |
| <input type="checkbox"/> Educational Reports | <input type="checkbox"/> Disciplinary Reports | <input type="checkbox"/> Testing Results |
| <input type="checkbox"/> Legal Documents/Information | <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Verbal Communications |
| <input type="checkbox"/> Alcohol/Drug Information | <input type="checkbox"/> Other: _____ | |

The disclosure of information is required for the following purpose(s):

- Coordination of Treatment and _____ services.
 Referral to/from _____.
 Other: _____.

I understand that this consent is revocable, in writing, at any time prior to its expiration, which will occur

On _____ or one year from today, whichever is later.

Patient's Signature

Date

Witness

For minor: Parent/Legal Guardian Signature

2520 Windy Hill Road #203, Marietta, Ga 30067
3950 Cobb Pkwy #803 & 805, Acworth, Ga 30101

555 Sun Valley Dr., Ste. K3, Roswell, GA 30076
327 Dahlonega St., Cumming, GA 30040

Phone: (770) 953-6401

Fax (770) 953-6015