550 Pharr Rd NE, Suite 605
Atlanta, GA 30305
Office 404-235-5982 Fax 678-705-2756
www.pathgroupatl.com

REQUEST FOR MEDICAL RECORDS

PATIENT NAME ___________________________________ **DATE OF BIRTH** ____________
(PLEASE PRINT)

Records Needed:

- ▢ Treatment Summary
- ▢ Discharge Summary
- ▢ Lab Tests
- ▢ Psychological Testing
- ▢ Psychiatric Evaluation
- ▢ Medical History
- ▢ Treatment Plan/Progress
- ▢ Drug/Alcohol Abuse/Addiction History
- ▢ Information Regarding Diagnosis, Medications and Behavior
- ▢ Other (please specify):

____

- ▢ All of the Above

Please release my records to:

____

____

Please obtain my records from:

____

____

By signing below, I am authorizing PATH Group of Atlanta, LLC to release my medical records to the persons or parties (as specified above) or to obtain my medical records from the person or parties listed above, accordingly. I understand that my records are confidential and will not be disclosed without my written consent unless under legal compulsion. I also understand that I may revoke this consent at any time, unless prior action has been taken into reliance, therein.

Patient Signature ____ Date _________________

Parent/Guardian Signature _________________________________ Date _________________

Witness Signature ____ Date _________________

Revised April 2016