Path Group of Atlanta, LLC
Psychiatry and Therapy Group

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name (please print): _____ Date of Birth: _____

I request and authorize _____ to release the health care information described below to/from:

Name: _____

Address: _____

Phone: _____ **FAX**:_____

This request and authorization applies to only the following protected health information:

_____

During the following time period or dates:

_____

I understand that, unless action has already been taken in reliance on this authorization, I may revoke this authorization at any time by making a written request to Path Group of Atlanta, LLC.

I understand that my express consent is required to release any health care information relating to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health or drug/alcohol treatment or use.

In accordance with Federal Government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1996 (HIPAA), in order for your healthcare provider or staff at PATH Group of Atlanta, LLC to discuss your condition or appointments with members of your family or other individuals that you designate herein, we must obtain your authorization prior to doing so. In the event of a critical episode, or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

_____ _____
Signature (patient or authorized representative) **Date**