

Authorization to Release Protected Health Information
Atlanta Area Family Psychiatry Clinic, PC
7000 Peachtree Dunwoody Road, Building 16, Suite 100
Atlanta, Georgia 30328-5754
770-393-1880 FAX: 770-393-1885
www.AAFPC.net

Last: _____ First: _____ MI: _____ / / _____
Print Patient's Full Name **Patient's Date of Birth**

_____ (____) _____ - _____
Print name of Parent, Legal Guardian, or Patient (if 18 years or older) **Day Phone**

Check (✓) one: I am the Patient (18 years of age or older) ; or Parent or Legal Guardian with custody
Relationship to the patient: _____

Records to be released **TO** or **FROM** or **TWO Way-TO & FROM**
Atlanta Area family Psychiatry Clinic, Check physician or therapist:

<input type="checkbox"/> Robert M. Slayden, M.D.	<input type="checkbox"/> Lyndon D. Waugh, M.D.	<input type="checkbox"/> LeNora M. Ashley, M.D.
<input type="checkbox"/> Todd W. Iwanicki, M.D.	<input type="checkbox"/> Elizabeth R. Slayden, M.D.	<input type="checkbox"/> Kelly Coffman, M.D., MPH
<input type="checkbox"/> Angel L. Perez, M.D.	<input type="checkbox"/> Susan S. Kirsch, M.D.	<input type="checkbox"/> Betsy A. Gard, Ph.D.
<input type="checkbox"/> Laura L. Mette, L.C.S.W.	<input type="checkbox"/> Allison Nitsche, M.D, M.P.H.	<input type="checkbox"/>

FROM or **TO** or **TWO Way-TO & FROM** whom you would like records to be exchanged:
3rd Party: _____
 Mail: _____

Street Address or PO Box Number
 _____, _____
City **State** **Zip**
OR
 Please fax or mail records: Fax to: (____) _____ - _____
 Telephone: (____) _____ - _____

Applicable Dates of Service: from _____ to _____

The purpose for which this release is being requested is:

- Coordination of or Continued Care;
- Legal Action/Review
- Insurance Reimbursement
- Other (specify) _____;
- Undeclared

Any disclosure of information by the recipient(s) is prohibited.

This authorization expires _____ (insert applicable date or insert "no expiration designated") or in 6 months (12 months for school requests), whichever is shorter, and no further use/disclosures may be made after the expiration. Authorizations apply only for medical records for specified treatment dates prior to and on the date of signature, unless otherwise specified.

Specified exceptions for future-dated releases are: School _____ Other _____

Date: ____ / ____ / 20__ Signature: _____

Witness: _____