

# Atlanta Area Psychological Associates, P.C.

## Consent to Release Confidential Information

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    1000 Cambridge Sq, Ste D, Alpharetta, GA 30004  
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