Family Psychiatry of Georgia, LLC
4180 providence Rd, #101, Marietta, GA 30062

Consent for Release of Medical Information:

Patient: _____ **DOB:**_____ **Address:** _____

I hereby authorize you to disclose protected health information (PHI), verbally or in writing, to the following individual(s):

Release From: _____ Release To: Dr N R-Malla / Family Psychiatry of Georgia

Phone: _____ Fax: _____ Phone: 678-500-8510 Fax: 678-500-9846

Address: _____ Address : 4180 Providence Rd, #101, Marietta, GA

_____ _____

Records Requested: ____ Medical History/Physical Exam _____ Laboratory Reports
_____Consultations _____ Discharge Summary _____ Summary of Hospitalizations
_____Progress Notes _____ Psychiatric Reports/Tests _____ Psychological Reports
_____Teachers' Reports _____ Psychiatric Evaluation _____ Medications
_____Social History _____ Treatment Recommendations
_____Course of Treatment _____ Developmental Hx
Other _____

Dates of records requested: From _____ **-** to _____

Records shall be used for: Consultation ☐ Continuation of care ☐ Second opinion ☐

Please deliver records by: Fax: ☐ to Attn: FPGa at (678) 500 9846

U.S. Mail ☐ Other ☐ _____

This consent is valid for 30 days from the date signed.

I hereby authorize "Release From" as stated above, to deliver to "Release To" as stated above the medical records as defined above by my _____ check marks. I, the patient or patient's representative have the legal right to inspect, copy and request delivery as specified of this
Protected Health Information within the next 30 days in accordance with Public Law 104-191 (HIPAA-1996). I accept the responsibility for any fees that may be associated with this request.

Patient Signature: _____ Date: _____

Patient's Legal Representative: _____ Date: _____
Or Guardian (it patient is a Minor)

Printed name of Legal Representative:_____