PEACHTREE PSYCHIATRIC PROFESSIONALS, P.C.

3520 Piedmont Road, N.E. Ste 330
Atlanta, GA 30305

Phone (404) 351-2008   Fax (404) 351-0243   Attn: Medical Records

Request for Medical Records

Patient's Name:_______________________________Date of Birth:____________
(Please Print)

Please check the appropriate box:

□Treatment Summary   □Discharge Summary   □Lab Tests/EKG Results

□Psychological Testing   □Psychiatric Evaluation   □Medical History

□Drug/Alcohol Abuse/Addiction History   □Treatment Plan/Progress

□Communication regarding Diagnosis, Medications & Behavior   □Other:_________________

□**ALL OF THE ABOVE**

Release My Records To:	**Obtain My Records From:**
__________________________	____________________________
__________________________	____________________________
__________________________	____________________________
__________________________	____________________________

By signing this form, I am giving authorization for my medical records to be released from Peachtree Psychiatric Professionals, P.C. to the party mentioned, or to be sent to Peachtree Psychiatric Professionals, P.C. from the party mentioned, 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, except to the extent that action has been taken in reliance therein.

Patient's Signature:______________________________________Date:______________

Parent/Guardian's Signature:________________________________Date:______________

Witness Signature:_______________________________________Date:______________

Peachtree Psychiatric Professionals, P.C.
3520 Piedmont Road, N.E., Ste 330
Atlanta, GA 30305
Phone 404-351-2008 Fax 404-351-0243