Lifeline Psychiatry LLC

2150 Peachford Rd, Ste. K, Atlanta, GA 30338
Ph: (770)458-0450, Fax: (770)458-0470

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____ I authorize **Lifeline Psychiatry LLC or Suneel Katragadda, MD** to disclose or release personally identifiable health information to the person, provider, and/or organization listed below.

_____ I authorize the **person, provider, and/or organization listed below** to release personally identifiable health information to **Lifeline Psychiatry LLC or Suneel Katragadda, MD.**

Person/Provider: _____

Address: _____

Phone: _____ Fax: _____

Person/Provider: _____

Address: _____

Phone: _____ Fax: _____

Organization/Facility: _____

Address: _____

Phone: _____ Fax: _____

Purpose of Disclosure**:** For receiving services or continuation of care at GA Psychiatric Services, LLC

Other: _____

MEDICAL INFORMATION AUTHORIZED FOR RELEASE (CHECK ONES THAT APPLY)

____ Psychiatric Evaluation
____ In-patient Psychiatric Records
____ Therapy Notes
____ Medication List
____ HIV testing / treatment records
____ Drug / Alcohol Abuse records
____ Psychological Evaluation
____ Out-patient Psychiatric Progress Notes
____ Discharge Summaries
____ Laboratory Results
____ Face Sheet or Demographics
____ Phone or Personal Communication

EXPIRATION

This authorization is valid from _____ to _____

I understand that this authorization expires in 180 days from the date of release if not noted above. I further understand that I may revoke this authorization anytime by written request and revocation becomes effective only from the date revocation is received.

PATIENT INFORMATION

Patient's Printed Name: _____ *Date of Birth:* _____

(IF PATIENT IS A MINOR)

Parent/Legal Guardian/Representative Name: _____

Relationship to Patient: _____

Signature: _____ ***Date:*** _____

Witness Name: _____ Signature: _____

Title: _____ Date: _____