NORTHWEST BEHAVIORAL MEDICINE
Authorization For Release of Information

Please fill out this portion of the form if you want another doctor to send your medical information to Northwest Behavioral Medicine.

Patient Name ______________________________ Date of Birth ________________ SSN ____________________

I ____________________(please print) hereby authorize __________________________ (please print) to release the following information to Northwest Behavioral Medicine for the purposes of continuing care for Psychiatric evaluation and treatment.

Dr.'s Name____

Dr.'s Address____

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Phone# ______________________________**Fax #**_______________________

(Without this information, we are unable to submit your request.)

Please check the office location where your records are to be mailed:

- ☐ 108 Margaret Avenue
Marietta, GA 30060
Ph. (770) 422-2009
Fax (770) 428-0330
- ☐ 11755 Pointe Place Suite A-1
Roswell, Ga. 30076
Ph. (770) 667-1264
Fax (770) 667-2238

Please check the information to be released to Northwest Behavioral Medicine:

- ☐ Academic and achievement record
- ☐ Behavioral and social observations
- ☐ Psycho educational testing including screening instruments, intelligence, and academic/achievement tests
- ☐ Progress notes
- ☐ Initial assessment Report
- ☐ Billing Reports
- ☐ Lab test results

Conditions:

The patient is voluntarily signing this authorization.
The patient reserves the right to refuse to sign this authorization.
The patient reserves the right to revoke this authorization at any time. This revocation must be in writing.
The patient may receive a copy of the signed authorization.
This authorization is in effect from ______________ to ________________ (length of time).

Signed: ____ Date: ________________________

07/20/16