

Atlanta, GA 30305 Office 404.235.5982 Fax 678.600.6566 pathgroupatl.com

REQUEST FOR MEDICAL RECORDS

PATIENT NAME		DATE OF BIRTH
(PLEAS	SE PRINT)	
Records Needed:		
☐ Treatment Summary ☐ Psychological Testing ☐ Treatment Plan/Progress ☐ Information regarding Dia ☐ Other (please specify): ☐ All of the Above	☐ Psychiatric Evaluation☐ Drug/Alcohol Abuse/Adagnosis, Medications and Be	☐ Medical History Idiction History ehavior
Please release my records to):	
Please obtain my records fro	om:	
records to the persons or pa the person or parties listed a confidential and will not be	rties (as specified above) or above, accordingly. I unders disclosed without my writte nd that I may revoke this co	-
Patient Signature		Date
Parent/Guardian Signature		Date
Witness Signature		Date