Path Group of Atlanta, LLC
Psychiatry and Therapy Group

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

In accordance with Federal Government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1996 (HIPAA), in order for your healthcare provider or staff at PATH Group of Atlanta, LLC to discuss your condition or appointments with members of your family or other individuals that you designate herein, we must obtain your authorization prior to doing so. In the event of a critical episode, or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

_____ **I do not authorize** PATH Group of Atlanta, LLC to release any or all information concerning my medical care to any individual except as noted above.

_____ **I do authorize** PATH Group of Atlanta, LLC to verbally release any or all information concerning my medical care to the following individual(s):

Name: _____
Relationship to Patient: _____ Phone #_____

Name: _____
Relationship to Patient: _____ Phone #_____

Name: _____
Relationship to Patient: _____ Phone #_____

Name: _____
Relationship to Patient: _____ Phone #_____

_____ _____
Patient Name Date of Birth

_____ _____
Patient / Parent / Legal Guardian Signature Date

_____
Name and relationship of Legally Authorized Representative