



Psychiatry and Therapy Group
550 Pharr Rd NE, Suite 305
Atlanta, GA 30305

Office 404.235.5982 Fax 678.600.6566
pathgroupatl.com

REQUEST FOR MEDICAL RECORDS

PATIENT NAME _____ DATE OF BIRTH _____
(PLEASE PRINT)

Records Needed:

- | | | |
|--|---|--|
| <input type="checkbox"/> Treatment Summary | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Lab Tests |
| <input type="checkbox"/> Psychological Testing | <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Medical History |
| <input type="checkbox"/> Treatment Plan/Progress | <input type="checkbox"/> Drug/Alcohol Abuse/Addiction History | |
| <input type="checkbox"/> Information regarding Diagnosis, Medications and Behavior | | |
| <input type="checkbox"/> Other (please specify): _____ | | |
| <input type="checkbox"/> All of the Above | | |

Please release my records to:

Please obtain my records from:

By signing below, I am authorizing PATH Group of Atlanta, LLC to release my medical records to the persons or parties (as specified above) or to obtain my medical records from the person or parties listed above, 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, unless prior action has been taken into reliance, therein.

Patient Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Witness Signature _____ Date _____