Path Group of Atlanta, LLC
Psychiatry and Therapy Group
550 Pharr Rd NE, Suite 305
Atlanta, GA 30305
Office 404.235.5982 Fax 678.705.2756
pathgroupatl.com

REQUEST FOR MEDICAL RECORDS

PATIENT NAME _____ **DATE OF BIRTH** _____
(PLEASE PRINT)

Records Needed:

- ☐ Treatment Summary
- ☐ Discharge Summary
- ☐ Lab Tests
- ☐ Psychological Testing
- ☐ Psychiatric Evaluation
- ☐ Medical History
- ☐ Treatment Plan/Progress
- ☐ Drug/Alcohol Abuse/Addiction History
- ☐ Information regarding Diagnosis, Medications and Behavior
- ☐ Other (please specify): _____
- ☐ 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 _____