WeCare Psychiatry Associates
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AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

Patient Name (Last, First, M.I.)	Date of Birth	Social Security Number

I HEREBY REQUEST AND AUTHORIZE MILIND JOSHI, M.D.
☐ TO RELEASE TO:_____ ☐ TO REQUEST FROM:_____

Name		Department / Facility		
Street Address	Suite	City	State	Zip Code
Telephone ( )		Fax ( )		

THE FOLLOWING INFORMATION

- ☐ Admission Note
- ☐ Psychiatric Evaluation
- ☐ Psychological Testing Report
- ☐ Social History
- ☐ History and Physical Examination
- ☐ Consultations
- ☐ Laboratory Reports
- ☐ Radiology Reports
- ☐ Progress Notes
- ☐ Discharge Summary
- ☐ Aftercare Plan / Recommendations
- ☐ Other _____
- ☐ Review and discuss my care as needed to coordinate treatment between providers

FOR THE PURPOSE OF

- ☐ Continued Treatment
- ☐ Other _____

I further agree to indemnify and hold harmless the party releasing the records from any liability that may arise from the release of the information herein requested.

If, on the judgment of the party releasing the records, disclosure of the privileged/confidential information will be harmful to the patient, release of such information may be withheld in accordance with specific State and Federal regulations. Records released may contain **alcohol and drug treatment information**, **AIDS/HIV**, **psychiatric/psychological/other mental health** privileged or confidential information. Certain communications are privileged and not subject to release without your consent under State and/or Federal law.

After giving due consideration to the above statement, I authorize the party specified above to furnish information, including electronic, photostatic or faxed copies of my medical record, including matters privileged under the laws of the State of Georgia, and applicable Federal laws and regulations, to the above organization/individual, or its agents.

I understand that this Authorization is subject to revocation, in writing at any time except to the extent that action has been taken in reliance thereof, and is only valid for a period of **One (1) Year** from the date of my signature, unless I specify another date or event here: _____

_____ _____
DATE SIGNED PATIENT SIGNATURE

_____ _____
WITNESS SIGNATURE LEGAL GUARDIAN SIGNATURE RELATIONSHIP

PROHIBITION ON REDISCLOSURE: ***This information may be protected by Federal Regulations (42CFR Part 2) which prohibits the recipient from making further disclosure.***