INTOWN ATLANTA
PSYCHIATRY

Medical Release of Information

By signing this form, you are giving consent for the provider to discuss your treatment with another party. The provider has the right to decline talking to a particular party about your treatment and medical care. The provider will only discuss pertinent medical details about your treatment. In addition, my provider at Intown Atlanta Psychiatry can share my medical records with the below designated person.

I, _____, would like to have my provider at Intown Atlanta Psychiatry contact _____ and discuss my psychiatric medical care. I am aware that my provider has an obligation to notify my contact if I am threatening to harm myself or others during our appointment, on the phone, or email. I also agree that my provider will not contact a third party if he/she does not feel it is relevant to my care or his/her scope of practice.

_____ _____

Patient Signature Date