Gwinnett Psychiatry, P.C.
170 Camden Hill Road, Suite C
Lawrenceville, GA 30045
Phone: (678) 226-2295 / Fax: (678) 226-2296

CONSENT FORM FOR RELEASE/SHARE INFORMATION

PATIENT NAME: _____

DATE OF BIRTH: _____ SSN: _____

LEGAL GUARDIAN IF PATIENT IS A MINOR: _____

I, _____, give my permission to Gwinnet Psychiatry and it's employees and the person (s) listed below to exchange information and /or records regarding myself or my dependents. I give permission for a faxed or photocopied signature to serve as an original regarding this release. The purpose of this release is to share/release information for the benefit of the patient's diagnosis, treatment planning, continuity of care, family medical leave, disability requests and/or benefit claims for life/health insurance application. The information released pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by the privacy act. This authorization may be revoked by the individual signing this consent by providing a written, signed and dated, request to withdraw the authorization except to the extent that action has already been taken.

1. _____
2. _____
3. _____
4. _____

_____ _____
Signature of Patient/Guardian Date Signed