Noel T. Rivers-Bulkeley, M.D.
ATLANTA PRIVATE PSYCHIATRY
4360 Chamblee Dunwoody Rd., Suite 530
Atlanta, GA 30341
(770) 454-8787 Fax: (770) 454-8744

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

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

I HEREBY REQUEST AND AUTHORIZE NOEL RIVERS-BULKELEY, 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
- ☐ Review and discuss my care as needed to coordinate treatment between providers
- ☐ Laboratory Reports
- ☐ Radiology Reports
- ☐ Progress Notes
- ☐ Discharge Summary
- ☐ Aftercare Plan / Recommendations
- ☐ Other ___________________________

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.***