BIOLOGIC BEHAVIORAL HEALTH
General Adult & Forensic Psychiatry

Consent to Release Confidential Information

(If you wish to grant permission for physician to share any information with a 3rd party)

I, _____

DOB: _____

Do hereby authorize:
Corey Beck, MD, or Patrick Robbins, MD, to receive from, release to, or exchange with:

_____
(Name or Agency)

_____
(Address or Phone Number)

The following information:
Any applicable behavioral health and/or substance abuse information, including diagnosis, treatment plan, prognosis, and medication (s) if necessary. I understand that information disclosed above is protected by Federal Regulation 42CFR, Part 2, and cannot be released without my written consent unless required by law. I understand that I need not consent to the disclosure of information to obtain treatment services. I choose to do so willingly and voluntarily. I understand that I may revoke this consent at any time by notifying Biologic Behavioral Health, in writing, except to the extent that action has been taken in good faith on my consent.

Patient Signature: _____ Date: _____

160 Clairemont Ave. Suite 150
Decatur, Ga 30030
P-404-824-1755
F-404-370-1324