3750 Palladian Village Drive, Suite 110
Marietta, Georgia 30066
Tel: (678) 2656-8361
Fax: (888-965-5219

Authorization for Release of Medical Information

Patient's Name: ____ Date of Birth: ________________________

Address: ____

City/State/Zip Code: ____

☐ I authorize StrongTower Behavioral Healthcare, LLC to **release information to:**

Name of Provider/Facility/Individual: ____

Address: ____

City/State/Zip Code: ____

Phone: ____________________________________ Fax: **(Required)** ____

☐ I authorize StrongTower Behavioral Healthcare, LLC to **obtain information from:**

Name of Provider/Facility/Individual: ____

Address: ____

City/State/Zip Code: ____

Phone: ____________________________________ Fax: **(Required)** ____

TYPE OF RECORDS REQUESTED/RELEASED: (check one)

☐ All Records ☐ Mental Health Records ☐ Lab reports ☐ __________________________

AUTHORIZATION VALID FOR: (check one)

☐ This date only
☐ One year from the date of this authorization OR ____________________ (insert date). This authorization applies to the records of the treatment received on or before the date of this authorization.
☐ This request is for records of any future treatment as listed above until ___________________ (insert date).

I understand that:

- My right to health care is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a written request to the address at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility above receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- There may be a charge for requested records.

Signature of Patient or Representative: ____

Date: ___________________________________ Relationship to Patient: _________________________________