Ronald Magat MD, LLC
Adult, Child and Adolescent Psychiatry
3830 Windermere Parkway Ste 304
Cumming, GA 30041
(678)680-3972 Fax (888) 519-4344

Authorization to obtain and/or Release Information

I,_____, hereby authorize Ronald Magat, MD to release and/or obtain information from the records of patient_____ (DOB:_____) for the purpose/s of:

1. Psychiatric Evaluation _____
2. Medication Evaluation _____
3. Ongoing Treatment _____
4. Insurance Request/Claims _____

The information to be released and/or obtained includes all or some of the following:

1. Psychiatric Evluation, Progress Notes, Course of Treatment, Medication History, Psychosocial History, Hospitalization Course, Discharge Summary
2. Psychological Testing Reports
3. Medical/Surgical Records
4. School Records
5. Lab/Imaging Reports
6. Juvenile Court Records
7. Other social agency reports

Release/Obtain information to/from:

Name_____

Address_____

Telephone/Fax/Email_____

PLEASE FORWARD INFORMATION TO THE ATTENTION OF DR. RONALD MAGAT

Authorization will remain in effect for:

_____ The time necessary to complete my treatment
_____ Duration of court mandate: Date_____

I understand that in order to protect confidentiality, my agreement to obtain and/or release information is necessary and this permission is limited for the purposes and to the person listed above. I also understand that unless otherwise limited by state or federal regulations (such as court mandate) I can cancel this consent at any time, except for action which has already been taken.

Signature of Patient or Parent/Legal Guardian_____

Signature of Physician_____

Date_____