



**Center for Family Psychiatry**

A Complete Approach to Mental Health

**AUTHORIZATION TO RELEASE MEDICAL/PSYCHIATRIC RECORDS**

With my signature below, I authorize:

Center for Family Psychiatry Inc.  
Suvrat J. Bhargave MD PC  
120 Handley Road, Suite 310  
Tyrone, GA 30290  
Tel: (770) 486-1011  
Fax: (770) 486-1067

\_\_\_\_\_ to obtain from:                      \_\_\_\_\_ to release to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ any and all records (to include psychiatric diagnosis and/or treatment records) for the period  
  
\_\_\_\_\_ onset of treatment and continuing  
  
\_\_\_\_\_ other \_\_\_\_\_  
\_\_\_\_\_  
  
\_\_\_\_\_ to discuss my care, treatment, diagnosis, and/or other pertinent recorded information

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Patient Name

This authorization shall remain in effect until I provide written notice. You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that my provider generally may not condition services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.