

## Sonali Bora M.D.

Child, Adolescent & Adult Psychiatrist
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## **Authorization to Obtain and/or Release Information**

I,, hereby authorize Integrated Psychiatri	c Services (IPS) to release an	nd/or
obtain information from the records of	(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 Evaluation, Progress Notes, Course of Treatment, Medication History, Hospitalization Course, Discharge Summary	Psychosocial History,	
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 and Fax		
PLEASE FORWARD INFORMATION TO THE ATTENTION OF INTEGRATED	PSYCHIATRIC SERVICE	S.
Authorization will remain in effect for:		
One year or until and earlier date specified here: Date		
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 rothis permission is limited for the purposes and to the person listed above. I also under by state or federal regulations (such as court mandate) I can cancel this consent at an already been taken.	rstand that unless otherwise	limited
Signature of Patient or Parent/Legal Guardian		
Signature of Provider		
Date		