DR. Kristian T. Jones

675 Seminole Ave. NE Unit T-03

Atlanta, ga 30307

t.404-249-0520 f. 844-270-0342

Authorization for Release of Mental Health and Therapy Records

|  |  |
| --- | --- |
| **Practice/Clinic Name** |  |
| **Care Provider** |  |
| **Address** |  |
| **Phone** |  |
| **Fax** |  |
| **Treatment Relationship** |  |

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, date of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize you to send or verbally communicate to Dr. Jones any requested portion of my mental health treatment records. Additionally, I give permission for Dr. Jones to communicate diagnosis and treatment information with you.

Records may be mailed to the address above or faxed to **844-270-0342**.

Thank you,

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

Patient’s signature Date