FORTNER
PSYCHIATRY LLC

Consent for Release of Information

I hereby authorize Jennifer Fortner, MD, to release/receive the mental health records of:

_____ _____
Name Date of Birth

This information is to be released to/from:

_____

_____

For the purpose of:
_____

Exclusions:
_____

I understand this authorization includes release of all medical records including records pertaining to HIV, mental illness, drug and/or alcohol abuse, venereal disease, and any other statutory protected diseases.

I also understand that I may cancel my consent for release of information at any time by stating so in writing with the date and my signature and delivering it to Jennifer Fortner, MD. The revocation does not include any information which has been shared between the time that I gave permission to share information and the time that it was revoked. If not revoked, this consent expires on case closing.

_____ _____
Signature Date

2295 Parklake Dr, Suite 430
Atlanta GA 30345
Phone: 404-800-5680
Fax: 678-712-7875