

Atlas Psychiatry | Nicholas G. Pejic MD

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Authorization to Release My Protected Health Information

By signing below, I authorize Nicholas G. Pejic MD to discuss my case or release my records to the indicated person or entity. I also authorize the indicated person or entity to discuss my case or release records to Nicholas G. Pejic MD in a reciprocal manner. This authorization will expire 12 months from date signed unless I revoke authorization in writing (letter or email to Dr. Pejic).

I understand that: I may refuse to sign this authorization and it is strictly voluntary. I release Atlas Psychiatry LLC and Nicholas G. Pejic MD, my physician, from any responsibility or liability of releasing this information. My treatment may not be conditioned on signing this authorization. I may revoke this authorization at any time, but if I do, it will not affect any actions taken prior to receiving the revocation. Letters to revoke this authorization should be addressed to Nicholas G. Pejic MD, 1301 Antonine Street, New Orleans, LA 70115 or emailed to AtlasPsych@gmail.com. Upon request, I have the right to a copy of this form after I sign it.

Person (or Entity) <u>receiving</u> or <u>sending</u> my protected health information:		
NAME		
ADDRESS:		
CITY	STATE	ZIP
PHONE:	FAX:	

**Purpose of Disclosure:**

- Transfer of Care     Family or Friend     Legal/Police     Psychologist/Therapist  
 Disability     Insurance     Military     College/School Administrative

**Information Requested:**

- All Records     Initial Evaluation, Last Two Progress Notes and/or Labs Results  
 Brain Imaging     Phone Call or Voicemail Disclosing Diagnosis, Treatment and Urine Toxicology  
 Psychological Testing     Information to Coordinate Care

PATIENT NAME:	DOB	Today's Date:
Phone:	SSN	
Signature:		