SHAW WENDI FORTUCHANG, M.D., P.C. / DBA: THE FORT CHRISTIAN PSYCHIATRIC CENTER
OFFICE OF
SHAW WENDI FORTUCHANG, MD, FAPA
ADULT, CHILD & ADOLESCENT AND FORENSIC PSYCHIATRY
110 NORTH PARK DRIVE, FAYETTEVILLE, GA 30214 ◆ (PHONE) 770-376-6726 ◆ (FAX) 770-376-6727

CONSENT FOR RELEASE OF INFORMATION

Patient's Name: _____ DOB: _____

I, _____, give consent for
The Fort Christian Psychiatric Center to receive my protected health information from and release it to:

Name of person / facility to receive my information: _____

Address: _____

Phone: _____ Fax: _____

The request and authorization applies only to the following information:

☐Medical History/Physical Exam	☑ Laboratory Test Results	☐Consultation Reports
☐Discharge Summary	☐Summary of Hospitalizations	☐Progress Notes
☐Psychiatric Reports/Tests	☐Psychological Reports/Tests	☐Teachers' Reports
☐Psychiatric Evaluation	☐Medication History	☐IEP/504 Plan
☐Treatment Recommendations	☐Course of Treatment	☑Fasting Labs

☑ Other: Baseline (and future routine) fasting labs. Lab order accompanied with this ROI Form.

The purpose of the release of information is: ☑Collaboration of Care ☐Continuation of Care

The release will remain in effect indefinitely, unless otherwise specified by you.

I understand that I can cancel this authorization at any time, except for action that has already been taken.

_____ _____
Signature of Patient (18 years and older) Date

_____ _____
Signature of Parent / Guardian Date

Be joyful in hope, patient in affliction, faithful in prayer. Romans 12:12