

**MIDDLE GEORGIA ORTHOPAEDIC  
SURGERY AND SPORTS MEDICINE  
3051 Watson Blvd., Warner Robins, GA 31093 (478)953-4563**

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

**Patient Information:** Chart No: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Maiden or prior name (if applicable) \_\_\_\_\_

**Please send my healthcare information to:**

**Check physician from:**

Name: \_\_\_\_\_

Dr. Banit  Dr. Malone

Address: \_\_\_\_\_

Dr. Easom  Dr. Phillips

City, State, Zip: \_\_\_\_\_

Dr. Jarrett  Dr. Wiley

Phone Number: \_\_\_\_\_

Attention: \_\_\_\_\_

**Information to be released:**

The most recent one-year of patient information (chart notes, labs, and special tests)

All medical records

Specific Information (please specify): \_\_\_\_\_

**Purpose for which disclosure is being made (please check one):**

Sharing with other healthcare provider

Personal use

I am transferring my care to a new healthcare provider

Legal investigation

Other: \_\_\_\_\_

**Patient Authorization:**

I understand that I am giving authorization for the release of certain private medical information to the above noted party. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under the Privacy Laws. I understand that I may revoke this authorization at any time.

Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**THIS AUTHORIZATION WILL EXPIRE 45 DAYS FROM THE DATE SIGNED**

**For more information on privacy visit our website at [www.mgo.md](http://www.mgo.md)**