CONSENT FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize to release the following information.
Including any treatment related to drugs or alcohol abuse, sexually transmitted diseases, psychological/psychiatric conditions, or AID/HIV condition from the medical records of:

NAME: **DOB:**

ADDRESS: **CITY/STATE/ZIP:**

INFORMATION FOR RELEASE

OFFICE NOTES: ☐ **X-RAYS:** ☐

LAB RESULTS: ☐ **PROVIDER CORRESPONDENCE:** ☐

OTHER: **ALL:** ☐

PURPOSE FOR THE RELEASE OF INFORMATION:

INFORMATION TO BE RELEASED TO:

Dr. John M. Henderson DO PC P: (706) 323-5717

1900 10th Ave., Suite 320 F: (855) 681-1414

Columbus, GA 31901

I understand the consent, except for the action already taken, can be withdrawn at any time in writing. This authorization will remain in effect for **90 days** after I sign and date this form below. Other conditions upon which this consent expires, if any:

This facility, it's employees, and physicians are released from any legal responsibility or liability for the release of the above medical records to the extent indicated and authorized herein.

Signature: **Date:**

Relation (If not self): Spouse **Witness:**