Physicians and Midwives of Macon
1062 Forsyth Street, Suite 3B
Macon, GA 31201
Phone: 478-743-3454 Fax: 478-743-6816
www.physiciansandmidwivesofmacon.com

Patient Authorization for Release of Medical Records

Patient Information

Name: _____

Date of Birth: ___ / ___ / _____

Address: _____

Phone Number: _____

I hereby authorize:

Practice/Facility Releasing Records:

Name: _____

Address: _____

Phone: _____

Fax: _____

To Release Information To:

Name/Facility: _____

Address: _____

Phone: _____

Fax: _____

Information To Be Released:

☐ Complete Medical Record

☐ Office Visit Notes

☐ Laboratory Results

☐ Radiology/Imaging Reports

☐ Billing Records

Physicians and Midwives of Macon
1062 Forsyth Street, Suite 3B
Macon, GA 31201
Phone: 478-743-3454 Fax: 478-743-6816
www.physiciansandmidwivesofmacon.com

☐ Other (specify): _____

Purpose of Disclosure:

☐ Continuity of Care

☐ Insurance/Payment

☐ Personal Use

☐ Legal

☐ Other: _____

Authorization Details:

This authorization will expire 12 months from the date signed unless otherwise specified: _____

I understand that I may revoke this authorization at any time by providing written notice to the releasing practice.

Revocation will not apply to records already released in good faith.

I understand that information disclosed may be subject to redisclosure and may no longer be protected by HIPAA once released.

I understand that treatment, payment, enrollment, or eligibility for benefits is not conditioned on signing this authorization.

Patient/Representative Signature

Signature: _____

Print Name: _____

Relationship (if not patient): _____

Date: ___ / ___ / _____