



Georgia Bone and Joint, LLC
1755 Hwy 34 East, Suite 2200
Newnan, GA 30265

Phone: 770-502-2162 Fax: 770-502-2169

Authorization to Release Medical Information

Patient Information

Patient's Full Name: SSN: Date of Birth:
Current Address:
City: State: Zip:
Patient's Phone #: (Work): (Cell):

Request Authorization

I hereby request and authorize the medical records from:

- Georgia Bone and Joint
Other Location:
Phone#: Fax#:

Release records to:

Name:
Address:
City: State: Zip:
Phone#: Fax#:
Secure Email:

I authorize the following person(s) to pick up my information:

Name:

Purpose of Release:

- At the request of the patient Insurance Medical Care

Information to be Released:

- Entire Medical Records GBJ Physical Therapy Work Release
X-Ray Disk FMLA Billing Statement
MRI Disk Disability Other - Specify

I understand that my medical record may also include information on diagnosis/treatment related to psychiatric or psychological conditions, drug and/or alcohol abuse, acquired immune deficiency syndrome (AIDS), and/or HIV status.

I understand that this consent is revocable by me, in writing, at any time except to the extent that action has been taken in reliance on it. I understand that this consent is valid for one year.

Signature of Patient/Legal Representative: Date:
Printed Name: (if not same as patient): Relationship to patient:
Witness Signature: Date: