STATESBORO WOMEN'S HEALTH SPECIALISTS

Please mark which Doctor you prefer to see.

___Gary B. Sullivan, MD, FACOG ___Lisa S. Rogers, MD, FACOG ___Barbara B. Williams, DO, FACOG

Type if Insurance:_____ Type of Appointment:_____

Mail or fax to: PO Box 1958, Statesboro, GA 30459 Phone: 912-871-2000 Fax: 912-871-2500

RELEASE AND/OR OBTAIN MEDICAL INFORMATION AUTHORIZATION

Patient name: _____ DOB:____/____/____
SSN: _____ Maiden name (if applicable):_____
Patient contact number - Home: _____Work: _____Cell:_____

1. I give my permission for Statesboro Women's Health Specialists:
   _____To release medical information to: _____To obtain medical information from:

Name of Facility:_____
Address: _____
Phone: _____Fax: _____
Specific information (if applicable): _____

2. I consent only to the release of information specifically name about and only to the specific person or agency named above.
3. I understand that I may withdraw my permission for the use of this information at any time except to the extent that it has already been used as previously authorized to take action on my behalf. In all cases, any consent given hereby shall have a duration no longer than that reasonably necessary to effectuate the purpose for which said consent is given. If I do not later withdraw this permission, it is my understanding that it will automatically expire in (60) days from the date of signature.
4. I am aware and specifically waive any privilege regarding the following information, which may or may not be contained in these records:

a) Communication made by me to a Psychiatrist (O.C.G.A. section 24-9-21).
b) Communication made by me to a Licensed Applied Psychologist (O.C.G.A. section 43-39-16).
c) Medical information concerning drug dependency (O.C.G.A. section 25-5-17).
d) Medical information concerning alcohol and drug dependency (O.C.G.A. section 37-7-166).
e) Medical information concerning mental retardation (O.C.G.A. section 37-4-125).
f) Medical information concerning alcohol and drug abuse (42CFR, part 2).
g) Medical information concerning Acquired Immune Deficiency Syndrome (AIDS).

Patient/Authorized Person Signature: _____ Date: ____/____/____

Relationship of Authorized Person: _____ Witness Signature: _____

The information released per this authorization has been disclosed from records protected by State and Federal confidentiality statutes. These statutes prohibit further disclosure of this information without the specific written consent of the patient.