Georgia Center for Reproductive Medicine
5354 Reynolds Street, Suite 510
Savannah, GA 31405
(912) 352-8588 • (912) 352-8893 FAX

Release And/Or Obtain Medical Information Authorization

Patient Name: _____ Birthdate:_____

SSN:_____ Maiden Name (if applicable):_____

Patient Contact Number: (home) _____ (work) _____ (cell) _____

1. I give permission for Georgia Center for Reproductive Medicine:

☐ to release medical information to: ☐ to obtain medical information from:

Name of Facility:_____

Address:_____

Phone Number:_____ Fax Number:_____

Specific Information (if applicable): _____

2. I consent only to the release of information specifically named above 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 in 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 60 days from the date pf signature.

4. I am aware ad specifically waive any privilege regarding the following information which 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 26-5-17).
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: _____

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