

**STATESBORO OB/GYN SPECIALISTS, P.C.**

**Sidney R. Washington, III, MD, FACOG  
Gary B. Sullivan, MD, FACOG  
Lisa S. Rogers, MD, FACOG**

**Barbara B. Williams, D.O, FACOG  
Todd Allen, MD, FACOG  
Barbara Peacock, FNP**

Mail or fax:  
P.O. Box 1958  
Statesboro, GA 30459  
(912) 871-2000  
Fax (912) 871-2500

**RELEASE AND/OR OBTAIN MEDICAL INFORMATION AUTHORIZATION**

Patient Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

SSN: \_\_\_\_\_ Maiden Name (if applicable): \_\_\_\_\_

Patient Contact Number: (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_

1. I give my permission for **Statesboro OB/GYN Specialists**:

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 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 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: \_\_\_\_\_

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.