Middle Georgia Family Dentistry

Dr. John Whittle, Dr. Tracy Gay, Dr. Trent Herring & Dr. Brandon Brown

2400 Bellevue Road Bldg 28
Dublin, Georgia 31021
478-272-1933
478-275-7973 (Fax)

Authorization for Release of Medical Information

Patient's name _____
Address _____
City/State/Zip Code _____
Patient's Phone # ( ) _____ Date of Birth _____
Date of Request _____ Date Needed _____

I authorize Whittle & Gay LLP **to release information to:**	❑ I authorize Whittle & Gay, LLP **to obtain information from:**
Name of Provider or Facility	Name of Provider or Facility
Address	Address
City, State, Zip Code	City, State, Zip Code
Phone # / Fax # (include area code)	Phone # / Fax # (include area code)

Type of records requested:
❑ All Medical records available ❑ X-ray Reports ❑ Insurance ❑ Billing
❑ Other _____
(Please describe.)

I understand that:
My right to healthcare treatment is not conditioned on this authorization
I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
There may be a charge for the requested records.

Signature of Patient or Representative _____ Date _____

Relationship to patient (If requester is not the patient) _____