# Middle Georgia Family Dentistry

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**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) _____