Ludwig V. Cavaliere, M.D. * Azmi A. Kabbani, M.D., F.A.C.P., F.A.S.N.
Thet N. Zaw, M.D.* Swathi Singanamala, M.D., M.R.C.P. *Adam Rhoades, PA-C
640 Martin Luther King Jr. Boulevard, Suite 200, Macon, Georgia 31201
P: (478)745-5455 * F: (478)745-2915 * www.maconmed.com

Authorization for Release of Medical Information

Patient Name: _____ D.O.B:_____

Street Address: _____ City/State/Zip: _____

I, _____, hereby authorize the use, disclosure and release of confidential health information about me to the practice listed below. Please include in my medical record all office notes, lab results, medical imaging reports and any other pertinent information in my medical record so that I may receive the best possible care.

Practice Requesting Records From:	**Please remit all records to:**
Name: _____ Address: _____ Address 2:_____ City/State/Zip:_____ Phone: _____ Fax:_____	Macon Medical Group 640 Martin Luther King Jr. Boulevard Suite 200 Macon, Georgia 31201 Phone: 478-745-5455 Fax: 478-745-5912

Disclosure Notices for Patient/Patient Representative:

1. I understand that the information in my medical records may include information relating to my health in addition to my personal information such as my name, and/or my child's name, date of birth, address, etc.
2. I hereby specify that this authorization extends to cover the release of information related to HIV testing and/or the treatment of AIDS related complex, or AIDS related conditions in addition to psychiatric and/or drug and alcohol abuse treatment information.
3. I understand that I may refuse to sign this authorization. My refusal to sign will not change my ability to get treatment, payment for treatment or eligibility for benefits. I may inspect or copy any information that has been either used or disclosed under this authorization.
4. I understand that I may revoke this authorization at any time by submitting a written request to the director of the organization where I am sending the Authorization. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I acknowledge that I am the patient, or am authorized to act on behalf of the patient and have read and fully understand this information. I was not coaxed or forced to give this consent. I understand that this authorization expires 90 days after the date of signature. I understand that at any time I may request a copy of this document for my personal records.

_____ _____

Signature of Patient/Authorized Representative Date