Janet E. Davis, M.D., P.C.

Maternal Fetal Medicine

Authorization for Release of Medical Information

I authorize ____________________________________ to release the following
Institute

from the medical record of ____
Patient's Name

to the following address:

Janet E. Davis, M.D., P.C.
1348 Walton Way, Suite 4300
Augusta, GA 30901
FAX: 706-722-7337

____ Medical

____ Operative Report

____ Discharge Summary

____ X-Ray Report

____ Pathology

____ Psychiatric

____ Psychological

____ Laboratory Data

____ EKG

____ Progress Notes

____ Consultation Report

____ Social History

____ Education

____ Drug/Alcohol Treatment

____ Other (Specify): ____

Concerning the period of care from ____________________ to ______________________.

State and Federal confidentiality provisions prohibit the release of the information specified above to any individual or agency other than the one indicated above. This release of information authorization can be revoked with written notification except to the extent that action has been taken. This consent is valid for 90 days after the date of signature.

____ ______________________

Signed by (circle one): Patient | Guardian | Parent of Minor Date

Patient's DOB: __________________________ Patient's SSN: _______-_____-_________