AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name:_____

Date of Birth: _____ SSN:_____

I authorize:

_____
_____
_____

To release healthcare information of the patient named above to:

Dr. Michael Blaney /Dr. Francisco Jacome /Dr. Dennis H. Jones/
Dr. Edward Boland/Dr. Mary Lu Thompson
Midtown Surgical Specialists
Live Healthy MD
3830 WashingtonRd Suite17
Martinez, GA 30907
Phone: 706-922-0440 Fax: 706-922-0441

This request and authorization applies to:

- o Healthcare information relating to the following treatment, condition or dates:
  _____
  _____
  _____
- o All healthcare information
- o Other:
  _____
  _____
  _____

Yes **No** I authorize the release of my SID results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the persons(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone..

Yes **No** I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature:_____ **Date:**_____