

4075 Elnora Drive
Macon, GA 31210
Phone: (478) 757-7888
Fax: (478) 757-7887



AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize

Name: _____

Address: _____

Phone: _____ Fax: _____

To release health care information of the patient named above to:

Name: Central Georgia Fertility Institute

Address: 4075 Elnora Drive Macon, GA 31210

Phone: 478-757-7888 Fax: 478-757-7887

This request and authorization applies to:

- Health care information relating to the following treatment, condition or dates:
*Please forward ONLY HSG reports, op notes, lab results, recent ultrasound reports, pap reports
(within last 12 months), spouse's semen analysis reports*

All health care information

Other: _____

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

CONFIDENTIALITY NOTICE:

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