

New Millennium Obstetrics & Gynecology, LLC
83 Upper Riverdale Road, Bldg 2 Suite 135
Riverdale, Georgia 30274
770-991-0778

AUTHORIZATION AND CONSENT FOR RELEASE OF INFORMATION

I, _____ authorize and request
from:

**Dr. Timothy B. Brown, Pandora T. Hardtman, CNM,
Judy T. Williamson, CNM and/or Kim Crom, NP
New Millennium Obstetrics & Gynecology, LLC
83 Upper Riverdale Road, Bldg 2 Suite 135
Riverdale, Georgia 30274 770-991-0778**

A complete copy of the Medical Records for: _____
Patient Name

To be sent to : _____
Name of Physician/Organization

Address: _____

Telephone: _____ Fax: _____

Email Address: _____

I am aware that some of the information in the requested Medical Records maybe of sensitive nature. By signing this release, I am granting permission for information pertaining to the below mentioned areas to be released. I waive any privilege or confidentiality existing under Federal or State Law regarding such information, including, but not limited to, protection afforded to:

- (1) Communications made to a Psychiatrist (O.C.G.A. 24-9-21)
- (2) Communications made to a Licensed Applied Psychologist (O.C.G.A.43-36-16)
- (3) Medical information concerning drug dependency (O.C.G.A. 26-5-17)
- (4) Medical information alcohol and drug dependency (O.C.G.A. 37-1-166)
- (5) Medical information regarding mental illness (O.C.G.A. 37-3-166)
- (6) Medical information concerning mental retardation (O.C.G.A. 37-4-126)
- (7) Medical information concerning alcohol and drug abuse (42-C.F.R. Part 2)
- (8) AIDS confidential information (O.C.G.A. 31-22-9 and 24-9-47)

This Authorization and Consent is in effect for 90 days. Our office will act on this release within the first week of receipt. The Authorization will terminate 90 days from the date appearing below.

Date: _____ Patient Name: _____

Birthdate _____ Signature _____

Patient or Authorized Person

Witness _____

Date Completed: _____