

**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:** \_\_\_\_\_

**Name of Physician**

**Address**

**Phone**

\_\_\_\_\_ **To Release to:** **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**

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: \_\_\_\_\_