INTERNAL MEDICINE ASSOCIATES OF MIDDLE GEORGIA
CRAIG CALDWELL, M.D. JEREMY T. GOODWIN, M.D.
97 Martin Luther King Jr. Drive, Forsyth, GA 31029
(478)994-1010 Fax (478) 994-1080

Authorization for Request of Health Information to be Released to Internal Medicine Associates of Middle Georgia

Dr. Craig Caldwell Dr. Jeremy T. Goodwin

By signing this form, I authorize Craig Caldwell, M.D./Jeremy T. Goodwin, M.D. to obtain the protected health information described below FROM:
Name and address of Person/Organization:

_____

_____

_____

Date: _____ This authorization expires upon fulfillment of request unless special circumstances noted _____
Purpose of disclosure (at request of patient, employment, insurance, medical care, etc) _____
I authorize the following information to be sent to Dr. Craig Caldwell/Dr. Jeremy T. Goodwin at 97 Martin Luther King Jr. Drive, Forsyth, GA 31029:
____ Copies of all medical records for the period _____ to _____

____ Copies of the information described below for period _____ to _____

____ History and Physical Examination ____ Lab, X-ray, etc Reports _____

____ Reports from Other Physicians ____ Other (Please specify) _____

I understand that this information may include any history of acquired immunodeficiency syndrome (AIDS): sexually transmitted diseases; human immunodeficiency virus (HIV) infection; behavioral health service/psychiatric care; treatment for alcohol and/or drug abuse; or similar conditions.

The following information should not be released, even if occurring during dates above:
_____
I understand that there may be information in these records that I would not want released.
I have been provided a copy of Craig Caldwell, M.D./Jeremy T. Goodwin, M.D.'s Notice of Privacy Practices and any charges that may be associated with this authorization. I have discussed any concerns that I may have about the use, release, and disclosure of my health information with Craig Caldwell, M.D./Jeremy T. Goodwin, M.D. or appropriate office personnel.

I understand that Craig Caldwell, M.D./Jeremy T. Goodwin, M.D. assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release Craig Caldwell, M.D./Jeremy T. Goodwin, M.D. from all legal liability that may arise from this authorization.

Patient's Signature _____ **Date** _____

Patient's Name: _____ SS# _____ Date of Birth _____
If the signature above is not that of the patient, I am acting for the patient because _____
My relationship to the patient is: _____. Signed _____
The patient or their representative may revoke this authorization by notifying in writing Craig Caldwell, M.D./Jeremy T. Goodwin, M.D.'s privacy officer. Federal law states that treatment, payment enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is prohibited by the Privacy Rule. Federal Law also requires a statement that there is the potential for the protected health information released under this authorization may be subject to redisclosure by the recipient.