MACON-BIBB COUNTY
RISK MANAGEMENT
PO Box 247, Macon, Georgia 31202-0247 | (478) 310.4137

AUTHORIZATION TO RELEASE MEDICAL RECORDS AND HEALTHCARE INFORMATION

Patients Name: _____ Date of Birth: _____

Previous Names (if applicable): _____ Last Four SSN: _____

I request and authorize _____ to release healthcare information and medical documentation of the above-named patient to:

Macon-Bibb County Risk Management
PO BOX 247
Macon, GA 31202-0247
risk.management@maconbibb.us

This request and authorization apply to:

◯ Healthcare information relating to the following treatment, condition, of the following:

_____

_____

◯ All healthcare information relating to visit(s) on the following date(s):

_____

◯ Other:

_____

Patient Signature: _____ Date Signed: _____

If a minor,

Guardian Signature: _____ Relationship: _____