SPIVEY
ORTHOPEDIC CLINIC

C. Mark Spivey, M.D. * J. Casey Spivey, MD

Board-Certified, Sports Trained Orthopedic Surgeon · Specializing in General Orthopedics and Sports Medicine

RELEASE/OBTAIN MEDICAL INFORMATION AUTHORIZATION

PATIENT NAME: _____ **DATE:** _____
DATE OF BIRTH: _____ **SS#:** _____

1. How do you prefer to receive you records?
   { }Paper Copy/Mailed { }Paper Copy/Pick Up
   { }Electronically-via CD { }Electronically-via Patient Portal
2. { } I give permission for Mark Spivey Orthopedic Clinic, LLC to RELEASE my medical records to: _____
   Reason for request: _____
3. { } I give permission for Mark Spivey Orthopedic Clinic, LLC to OBTAIN my records from: _____
4. I consent only to release of information specifically named above and only to the specific person or agency named above.
5. I understand that I may withdraw my permission for the use of this information at any time except to the extent that it has already been used as previously authorized to take action in my behalf. In all cases, any consent given hereby shall have duration no longer than that that is reasonably necessary to effectuate the purpose for which said consent is given. If I do not later withdraw this permission, it is understood that it will automatically expire sixty (60) days from the date of the signature.
6. I am aware and specifically waive any privilege regarding the following information which may or may not be contained in these records.
   *Communication made by me to a psychiatrist (O.C.G.A. section 24-9-21)
   *Communication made by me to a licensed Applied Psychologist (O.C.G.A. section 43-39-16)
   *Medical information concerning drug dependency (O.C.G.A. section 26-5-17)
   *Medical information concerning alcohol and drug dependency (O.C.G.A. section 37-7-166)
   *Medical information concerning mental retardation (O.C.G.A. section 37-4-125)
   *Medical information concerning alcohol and drug abuse (42CFR, part 2)
   *Medical information concerning Acquired Immune Deficiency Syndrome (AIDS)

_____ _____
Patient or Authorized Person Witness

_____
Relationship of Authorized Person