

Edward J. Fisher, Jr., M.D., Inc.
Edward J. Fisher, Jr., M.D.
1360 Caduceus Way, Building 400, Ste. 102
Watkinsville, Georgia 30677-7351
706-286-8442 - (fax) 706-310-6907

CONSENT FORM FOR RELEASE/SHARE INFORMATION

PATIENT NAME: _____

DATE OF BIRTH: _____ SSN: _____

LEGAL GUARDIAN IF PATIENT IS A MINOR: _____

I, _____, give my permission to Edward J. Fisher Jr., MD Inc., it's employees and the person (s) and/or entity (s) and it's employees, listed below to exchange information and/or records regarding the identified patient as stated above. I give permission for a faxed or photocopied signature to serve as an original regarding this release. The purpose of this release is to share/release information for the benefit of the patient's diagnosis, treatment planning, continuity of care, family medical leave, disability requests and/or benefit claims for life/health insurance application. The information released pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by the privacy act. This authorization may be revoked by the individual signing this consent by providing a written, signed and dated, request to withdraw the authorization except to the extent that action has already been taken.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Signature of Patient/Guardian

Date Signed