GEORGIA DEPARTMENT OF CORRECTIONS

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

TO HEALTH CARE PROVIDERS & TREATING PHYSICIANS:

This authorizes you to give the official representatives of the Georgia Department of Corrections (GDC) and its agents any information, data or records you have regarding my medical history and/or treatment (including records pertaining to psychiatric, drug and alcohol use, and any medical condition I may have or have had); and any information, data or records pertaining to evaluations I have received, which are needed to assess my fitness for performance of assigned duties, job functions, and work responsibilities.

This authorization is valid only during the period of my employment with GDC, and with the knowledge and understanding that *any information obtained by my employer, pertaining to my medical condition or history, must be kept confidential* and may only be released to specific persons and entities authorized by law.

For all purposes described herein, a photocopy of this authorization is as valid as the original document.

Printed or Typed Name	**Employee Signature**
Social Security #	**Employee ID #**
Date	

Record Retention: Retain permanently in the employee's local medical file.