

MACON GYN-OB ASSOCIATES, PA

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Permission to Authorize Treatment

Patient Name: _____ Date of Birth: _____
(please print)

I hearby give my permission to the person(s) listed below to authorize treatment and to receive information about the care of the above named patient.

Name	Relationship	Phone Number

Signature of Patient
(must be signed by patient if 12 years or older)

Date

In order to obtain information by telephone, the party calling (only those listed above) must share the patients identifier listed below with the staff. Please fill date of birth. If the caller does not give the information you have chosen below, information may not be given out.

Patient Identifier:

Date of Birth: _____