

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

AUTHORIZATION AND CONSENT TO RELEASE MEDICAL INFORMATION

Instructions: This form shall not be filed with the Board, unless otherwise requested

TO:		
Print Name and Title		
Address		
City	State	Zip Code

RE: Employee / Patient		
Last Name	First Name	M.I.
SSN	Date of Injury	Birthdate

This document authorizes the release of only the medical information as provided below. The above-stated entity, facility or medical practitioner is authorized to release medical information to

_____ in accordance with applicable State and Federal laws.

The information covered by this Authorization and Consent to Release is that authorized by O.C.G.A. §34-9-207 which reads as follows:

CLICK OR RIGHT CLICK THE LINK BELOW FOR THE MOST RECENT VERSION OF THIS FORM

[HTTPS://SBWC.GEORGIA.GOV/DOCUMENT/BOARD-FORM/WC-207/DOWNLOAD](https://sbwc.georgia.gov/document/board-form/wc-207/download)