Copy of Picture ID Required

Medical Information Release Consent

First Name ____ Middle ____ Last ____

Employee ID ____ Maiden/Former Name ____

Telephone Number ____ Date of Birth ____

Are you a current employee of Wellstar? ☐ Yes ☐ No

If no, approximate month and year you last worked: ____________________

Which facility do you (or did you) work for?

☐ **Cobb Hospital Employee Health**
Office: (470) 732-2248
Fax: (470) 732-7212

☐ **Douglas Hospital Employee Health**
Office: (470) 644-6864
Fax: (678) 715-1031

☐ **Kennestone Hospital Employee Health**
Office: (770) 793-7222
Fax: (770) 793-7952

☐ **AMC - Downtown Employee Health**
Office: (404) 265-4322
Fax: (404) 265-6180

☐ **AMC South Employee Health**
Office: (404) 466
Fax: (404) 466-8170

☐ **Spalding/Sylvan Grove Employee Health**
Office: (770) 228-2721
Fax: (770) 467-6328

☐ **North Fulton Hospital Employee Health**
Office: (770) 751-2856
Fax: (770) 751-2659

☐ **Paulding Hospital Employee Health**
Office: (470) 644-8025
Fax: (470) 644-7363

☐ **Windy Hill Hospital Employee Health**
Office: (770) 644-1162
Fax: (770) 644-1166

☐ **WGMC Employee Health**
Office: (706) 845-3125
Fax: (706) 845-3412

Document is to be:

☐ Picked up ☐ Faxed to: ____________________

☐ Mailed to: ____________________ ☐ Email to: ____________________

I, ______________________________ , hereby release Wellstar Health System's Employee Health Office from any liabilities, damages and claims arising from the release of information authorized above. I give my permission for this information to be used for the following purposes: ______________________________ , but I do not give permission for any other use or re-disclosure of this information. I acknowledge that this consent is valid for 60 days or until ____________________ .

Full Name of Team Member or Legal Representative ____

Signature of Team Member or Legal Representative ____