

**DIGESTIVE HEALTHCARE OF GEORGIA, P.C.**

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**Authorization to Release Medical Records to Digestive Healthcare of Georgia, P.C.**

**Date:** \_\_\_\_\_

**TO:** \_\_\_\_\_ **Ph:** (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

\_\_\_\_\_ **Fx:** (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I, \_\_\_\_\_, am currently under the care of Digestive

**Patient Name (Please Print)**

Healthcare of Georgia, P.C. I am hereby authorizing the release of my medical records to Digestive Healthcare of Georgia so my provider(s) can review these records to better manage my medical care and make informed medical decisions.

**Patient:** \_\_\_\_\_ **DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Last 4 SS#:** \_\_\_\_\_ **Ph:** (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **Cell:** (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Please send these records to my Physician prior to my appointment on:** \_\_\_\_\_

**Records to be released:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Specify Treatment Date(s):** \_\_\_\_\_

I release \_\_\_\_\_ from all legal responsibility or liability that may

**Name of Physician/Facility Releasing Records**

arise from this authorization. I understand that this release only pertains to the medical records specified and that a separate authorization must be completed to initiate further requests for release of additional medical records. Please forward these records to the physician/provider noted above. This release will remain valid until I decide to revoke this authorization. However, I understand that cancelling this release will not pertain to records already released.

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Witness Signature**

\_\_\_\_\_  
**Date**