DIGESTIVE HEALTHCARE OF GEORGIA, P.C.

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

Date:	<u></u>	
Patient:	DOB:	
Last 4 SS#: Home Ph: ()	Cell/Wk (
Home/Mailing Address:		
CITY	STATE	ZIP CODE
I,	, authorize Digestive F	Healthcare of Georgia, P.C.
Name:		
Address:		
City:	State: Z	ip Code:
Ph: (Fax: ()	
Records to be released:		
Specify Treatment Date(s):		
I release Digestive Healthcare of Georgia, P.C. from a	all legal responsibility or liability that m	nay arise from this
authorization. I understand that this release only pertain	ins to the medical records specified and	that a separate authorization
must be completed to initiate further requests for relea	se of additional medical records.	
Patient Signature		Date
Witness Signature	<u> </u>	Date