DIGESTIVE HEALTHCARE OF GEORGIA, P.C.
1265 Highway 54 West, Suite 402
Fayetteville, GA 30214

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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**