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Rachel Bartolomei, NP/ Hannah Folds, NP/ Kelsey Beyer, NP/ Nicole Pickett, NP
Orlena Wyatt, NP/ Angela Long, NP/ Jena Thomas, NP/ Kayla Jones, NP

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

Date: _____

Patient: _____ **DOB:** _____/_____/_____

Last 4 SS#: _____ **Home Ph:** (_____) _____ - _____ **Cell/Wk** (_____) _____ - _____

Home/Mailing Address: _____

_____ _____ _____
CITY **STATE** **ZIP CODE**

I, _____, authorize Digestive Healthcare of Georgia, P.C.
Patient Name (Please Print)
to provide copies of my medical record to:

Name: _____

Address: _____

_____

City: _____ **State:** _____ **Zip Code:** _____

Ph: (_____) _____ - _____ **Fax:** (_____) _____ - _____

Records to be released: _____

_____

_____

Specify Treatment Date(s): _____

I release *Digestive Healthcare of Georgia, P.C.* from all legal responsibility or liability that may 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.

_____ _____
Patient Signature (This authorization is valid for 90 days) **Date**

_____ _____
Witness Signature **Date**