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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