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

TO: _____ Ph: (_____) _____ - _____
_____ Fx: (_____) _____ - _____

I certify that I am currently under the care of Digestive 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 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/Representative Signature (This authorization is valid for 90 days) _____ Date _____
Witness Signature _____ Date _____