DIGESTIVE HEALTHCARE OF GEORGIA, P.C.

134 Mountainside Village Parkway, Building 500 • Jasper, GA 30143
Telephone (706) 253-7340 • Fax (706) 253-7342

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name: _____	DOB: _____
Last 4 of SSN: _____	Daytime Phone Number: _____

SELECT ONLY ONE OF THE THREE OPTIONS BELOW

1. _____ I am requesting a copy of my medical records

2. _____ I am authorizing you to request my medical records from:

Name of Physician or Facility:

_____

Address:

_____

City: _____ State: _____ Zip: _____

Office: _____ Fax: _____

Requested Records:

_____

Reason for Request:

_____

3. _____ I am requesting that you send a copy of medical records to the physician below

Name of Physician or Facility:

_____

Address: _____

City: _____ State: _____ Zip: _____

Office#: _____ Fax: _____

_____ _____

Patient Signature Date (Valid for 90 Days)

_____ _____

Witness Signature Date (Valid for 90 Days)