DIGESTIVE HEALTHCARE OF GEORGIA, P.C.

1265 Highway 54 West
Fayetteville, GA 30214
770-719-3240 ext. 1456 (Medical Records)

□ John Burney, III, M.D. □ Kiran Kanji, M.D. □ Bryan Woods, M.D. □David Rudolph, D.O. □Clara Antoury, M.D.
□ David Gryboski, M.D. □ Niraj Khandelwal, M.D., M.H.S. □Aniruddh Patel, M.D. □William E. Norris, M.D. □Nikhil Kadle, M.D.

Rachel Bartolomei, NP/ Hannah Folds, NP/ Kelsey Beyer, NP/ Nicole Pickett, NP
Orlena Wyatt, FNP-C/ Angela Long, FNP-C/ Jena Thomas, NP / Angela Johnson, NP

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patients Name: _____ **DOB**: _____

Last 4 of SSN: _____**Daytime Phone Number**: _____

SELECT ONLY ONE OF THE THREE OPTIONS LISTED BELOW
IF YOU HAVE MORE THAN ONE PHYICIAN/ FACILITY TO REQUEST FROM, YOU MUST FILL OUT MORE THAN ONE FORM

1. _____**I am** requesting a copy of my medical records. *Specify Treatment Date(s):* _____

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

Name of Physician or Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

Office#: _____ Fax: _____

and furnish to DIGESTIVE HEALTHCARE OF GEORGIA, P.C. I understand that I release my physician(s) from all legal aspects that may arise from this authorization.

Specify Treatment Date(s): _____

3._____**I am** requesting that you send a copy of medical records to the physician below: I also understand that this file may contain sensitive information such as treatment for AIDS, HIV infection, Mental Health, alcohol and/or drug and hepatitis. *Specify Treatment Date(s):* _____

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)