Digestive Healthcare Of Georgia, P.C.
95 Collier Road, NE Suite 4075
Atlanta, Ga. 30309
Tel: (4040 355-3200 x1163
Fax: (404) 343-3724

AUTHORIZATION TO RELEASE

Patient's Name: **DOB:**
SS# _____ Day Time Phone No:

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

2. _____I am authorizing you to request my medical records from_____
_____ Phone No: _____
Fax No:_____ 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.

3. _____ I am requesting that you send a copy of my 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.

Name of Physician or Facility:
_____
Address: _____
City: _____State: _____ Zip:

Phone No:_____ Fax No __
(Required) (Required)

X _____ X _____
Patient's Signature Date (Valid for 90 days)

_____
WITNESS

You may fax this form back to 404 343-3724 or mail to the below address.
Digestive Healthcare of Georgia, P.C.
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Atlanta, Georgia 30309