Gastroenterology Atlanta LLC

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MEDICAL RECORDS RELEASE

I hereby authorize Gastroenterology Atlanta LLC to release/obtain my complete health record.

RE: Patient Name: ____

Date of Birth: _________________ Social Security Number: _____________________

TO/FROM: ____

Name of Healthcare Provider/Physician/Facility/Medicare Contractor

____

Street Address

____

City, State and Zip Code

_____________________________ _________________________________

Phone number Fax number

I hereby release Gastroenterology Atlanta LLC from any liability which may result from this disclosure of confidential medical information, or which may arise as a result of the use of the information contained in the information released. I understand that I may revoke this authorization by providing written notice of my intention. Unless withdrawn, this consent will expire in thirty (30) days from the date signed.

_______________________________________ _________________________________

Signature of Patient or Legally Authorized Representative Date

____ _________________________________

Printed Name of Patient or Legally Authorized Representative Relationship if other than patient

____ _________________________________

Witness Signature Date