Athens Digestive Healthcare Associates
1360 Caduceus Way
Building 300
Watkinsville, GA 30677
Phone: (706) 850-4985 Fax: (706) 850-4989

MEDICAL RECORDS RELEASE

Date: _____

To: _____

_____

Office Number: _____ Fax Number: _____

I hereby authorize you to release my records to:

Athens Digestive Healthcare Association :

Office Number: (706) 850-4985 Fax Number: (706) 850-4989

Any information including the diagnosis and records of any treatment or examination

-rendered to me from _____ to _____ .

_____
Print Name

_____
Signature

_____
Date of Birth

_____ _____
Witness Date