Incoming Record Release

MEDICAL RECORD RELEASE

Date: ___________________________

TO: ____

ADDRESS: ____

PHONE # ___________________________ FAX # ________________________

I hereby authorize you to release my medical records to:

DR JEFFREY WILLIAMS
ATHENS GASTROENTEROLOGY ASSOCIATION
3320 OLD JEFFERSON ROAD, BUILDING 400
ATHENS, GA 30607

OFFICE # (706) 613 – 1625 **FAX # (706) 613 – 1629**

Any information including the diagnosis and records of any treatment or examination rendered to me from: _________________________ to __________________________

____
Patients Name

____
Patients Signature

______________________ / ______________________
Date of Birth **Social Security Number**

____
Witness