**Date: _____**

## I hereby authorize the release of my medical records from

Dr Jeff Williams / Athens Gastroenterology Association

3320 Old Jefferson Rd, Building 400 Athens, Ga 30607

Phone: (706) 613 – 1625 Fax: (706) 613 – 1629

## To be released to the following:

_____

Physician Name / Facility

_____

Address

_____

Phone Number Fax Number

_____

Patient Name

_____

Patient Signature

_____ / _____

Date of Birth Social Security Number