

Jeff M. Williams, MD
Board Certified Gastroenterologist



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3320 Old Jefferson Road
Building 400
Athens, GA 30607
(706) 613-1625 Phone
(706) 613-1629 Fax

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 _____.

Patient name

Patient signature

_____/_____
Date of birth SSN

Witness

Lavonia
St. Mary's Sacred Heart
367 Clear Creek Drive
Suite 2007
Lavonia, GA 30553

Greensboro
Tender Care Clinic
803 South Main Street
Greensboro, GA 30642

Hartwell
Hartwell Family
Practice
229 Athens St.
Hartwell, GA 30643

Madison
Morgan Medical
Center
1740 Lions Club
Suite 100
Madison, GA 30650

Commerce
Northridge Specialty
Clinic
209 Mercer Place
Commerce, GA 30529