Jeff M. Williams, MD
Board Certified Gastroenterologist

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3320 Old Jefferson Road
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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