GASTROLENTEROLOGY & NU TRITION CLINICS,P.C.

Stomach, Colon, Liver, & Nutritional Health

Mailing Address: 3040 Highlands PARKWAY SUITE C –Smyrna, Ga. 30082

Phone: (404)681-0000 Fax: (678) 866-2538

REQUEST FOR RELEASE OF MEDICAL RECORDS

DATE: ______________________

TO: ______________________

ADDRESS: ____

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I hereby authorize you to release to **GASTROENTEROLOGY & NUTRITION CLINICS, P.C.** all information and records in your keeping of any and all examinations, procedures, and treatments rendered to me during the following period:

______________________ to ______________________.

______________________________ Full Name of Patient (Please Print)

______________________ SSN or Date of Birth

______________________________ Signature of Patient or Responsible Party

______________________ Date

______________________________ Name of Person giving consent (Please Print)

______________________ Relationship to Patient

______________________________ Witness

______________________ Date

☐ Patient unable to sign (reason) ______________________________________.

Please Forward to: **Gastroenterology & Nutrition Clinics, P.C.**

3040 Highlands Parkway Suite C

Smyrna, Ga. 30082