11 John Maddox Drive
Rome, GA. 30165
(706)295-3992 phone
(706)378-5582 fax

AUTHORIZATION TO RELEASE/OBTAIN MEDICAL INFORMATION

____
Patient Name

______________ ____________________
DOB Social Security #

Mail ____________ Pick up ______________________

I Authorize:

____
Name of sending person/organization

____
Street Address

____
City State Zip

To Release To:

____
Name of receiving person/organization

____
Street Address

____
City State Zip

Information to be released:

□ ENTIRE record for the past 3 years

□ LIMIT INFORMATION (to only those items checked below)

□ Physical examination records, including treatment for mental illness, alcohol or drug abuse, or HIV/AIDS.
□ Lab results
□ X-ray results
□ Other (specify) ______________________________

Reason for Disclosure: □ Continuity of Care □ Personal Use □ Consultation □ Social Security
□ Employer's request □ Form Completion □Attorney Inquiry □Ins. Claim □Other (specify)____________

- I understand that I, or the person authorized to act on my behalf, am entitled to receive a copy of this authorization.
- The requester may be provided with a copy of this authorization.
- I am authorizing any physician, nurse, hospital, or other provider having treated or attended me and having possession of any records and/or information with respect thereto, to provide such records to the requesting party identified above.

By signing below you are hereby authorizing Rome Gastroenterology Associates to request/release the requested information identified above.

_______________________________ ____________________ _______________________________
Patient or Parent/Guardian Signature Daytime Phone # Date

_______________________________ _______________________________
Signature of Witness Date

Version 2.0