Bruce A. Salzberg M.D., F.A.C.G

www.atlgastrospec.com

678-957-0057

Authorization to Release Medical Records

Patient Name:

Date of Birth SSN#

Send records to: **Atlanta Gastroenterology Specialists**
Attention: Patient Records
4395 Johns Creek Parkway, Suite 130
Suwanee, Georgia 30024
Fax: 678-957-0047

Specific Description of Information – indicate treatment dates for each requested item

X Office Notes From _____ To_____ ☐ xxRadiology Reports From _____ To_____

X Lab Reports From _____ To _____ ☐ xxPathology Reports From _____ To _____

☒ Proc Reports From _____ To _____ ☐ **xx Entire Record – all documents listed above without exception**

The information described above will be used or disclosed for the following purpose(s):
☒Continuity of care ☐Transfer of care

To be completed by the patient or personal representative:

I hereby authorize the use or disclosure of my protected health information as described above. I understand that this authorization is voluntary. I understand that the ability to obtain treatment will not be affected if I do not sign this form, unless that treatment is for a fitness-for-duty evaluation or a records-related treatment. I understand that if the organization authorized to receive the information is not required to comply with the federal privacy protection regulations then such information may be re-disclosed and will no longer be protected. I understand that I have a right to revoke this authorization by sending written notification to: Atlanta Gastroenterology Specialists PC 4395 Johns Creek Pkwy Ste 130 Suwanee GA 30024 Any revocation will not affect disclosures made prior to Atlanta Gastro Specialists PC receipt of knowledge of the revocation.

I understand that I have a right to inspect and receive a copy of the information described on this form. I certify that I have received a copy of this authorization.

Signature of patient or patient's rep | Printed name of patient's representative | Relationship to patient

Date: _____

Expiration date of authorization:_____(unless otherwise noted, this authorization will expire 12 months from the date of signature)