Gastroenterologists:
Robert P. Albares, M.D.
Samuel J. Tarwater, M.D., FACG
Travis J. Rutland, M.D., FACG
Marc L. Clark, M.D.
Paul B. Lamb, M.D.

Digestive Health Specialists
OF THE SOUTHEAST

Gastroenterologists:
S. Andrew Sarrels, M.D.
Tyler P. Black, M.D.
George A. Nelson, IV M.D.
Adam L. Edwards, M.D.
Benjamin A. Hewitt, M.D.

Pathologist:
Beth M. Rutland, M.D.

Authorization for Release of Medical Records

Patient Name: _____ Date of Birth: _____

Address: _____ City, State, Zip Code: _____

Phone (Main) _____ Phone (Secondary) _____

REQUESTED RECORDS FROM

Facility Name: _____ Facility Phone: _____

Facility Address: _____ Facility Phone: _____

____Entire Record ____Office Notes ____Procedure Notes ____Path Reports ____ Lab Results ____Radiology Results

____Other (Please Specify): _____

RELEASE RECORDS TO

Name: _____ Phone: _____

Address: _____ Fax: _____

____Please Mail Records ____Please Fax Records

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not have to complete this form in order to assure treatment. I understand I can revoke this authorization at any time, I must do so in writing and present my written revocation to the Medical Records Department of Digestive Health Specialists.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I fully understand the terms and conditions of this authorization.

X_____ _____
Signature of Patient/Parent/Guardian or Authorized Representative **Date**

X_____ _____
Signature of Patient/Parent/Guardian or Authorized Representative **Date**