ATLANTA gastroenterology
PART OF UNITED DIGESTIVE

MEDICAL RECORDS RELEASE

Date _____

Patient Name _____ Date of Birth _____

I hereby authorize and request you to release complete medical records
in your possession concerning my illness and/or treatment.

Recipient ❑ Hospital ❑ Physician ❑ Self ❑ Other _____
Method ❑ Email ❑ Fax ❑ Mail ❑ Patient Portal ❑ Pick-up at AGA office

Recipient contact information (complete all applicable information)

Name _____

Address _____

Phone _____ Fax _____ Email _____

❑ Release all records

❑ Release only the records from the period between _____ and _____

Under Federal law, a patient may request a copy of his or her medical records.
A fee may be charged for this service in accordance with Georgia law.

Patient Signature* _____ Date _____

**If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.*

Requestor information (if not the patient)

Name _____ Relationship to patient _____

Requestor's Signature _____ Date _____

Fax or mail this completed form and a copy of the requestor's photo ID to any AGA location. Office addresses and fax numbers may be found at www.atlantagastro.com/locations. You may also email these required documents to medicalrecords@atlantagastro.com. If picking up records in person, a photo ID will be required at the time of pick-up.