Johns Creek Gastroenterology

Clive Albert, M.D

Records Release

Date: _____

To: _____

_____

_____

I hereby authorize you to release to:

Johns Creek Gastroenterology, PC
1100 Northside Forsyth Drive
Suite 330
Cumming, GA 30041

Any information including the diagnosis and records of any treatment or examination rendered to me during the period from _____ to _____

_____
Signature

_____ _____
Witness Name

_____
Date of Birth

1100 Northside Forsyth Drive, Suite 330, Cumming, GA 30041
4040 Johns Creek Parkway, Suite 100, Suwanee, GA 30024
Tel: (770) 889-9901 Fax: (770) 889-9088
www.johnscreekgastro.com