The Georgia Gastroenterology Center
1014 Forsyth Street, Suite 300
Macon, GA 31201
(478) 633-8700

Patient's Name Legal Guardian's Name

Patient's DOB Patient's Social Security Number

I, _____ (patient/parent/guardian) do hereby authorize the Gastroenterology Center to discuss the medical treatment, results of any labs or x-rays or other procedures for _____ (patient name) with the following individual(s):

NAME RELATIONSHIP

1) _____

2) _____

3) _____

4) _____

Due to my signature below on this authorization the Gastroenterology Center will not b e held liable if my medical treatment is discussed or released to the above-referenced persons. This authorization will be in effect until such time as I change the person(s) referenced or withdraw permission.

I specifically do not authorize any medical treatment to be discussed with the follow individual(s):

1) _____

2) _____

Date _____ Signature _____
Patient/Legal Guardian