



MEDICAL RELEASE OF INFORMATION

Patient Name: _____ Date of Birth: ____/____/____

This is Form intended as a Release of healthcare Information to:

Georgia Hemorrhoid Institute

FAX: 404.868.3363

I _____ (please print clearly) request and authorize the release of Healthcare Information including the diagnosis, records; physical examination, diagnostic imaging, labs and treatment plan rendered to me.

Should you have any questions, Please call my: my home my work my cell
Number: _____ Alternate number: _____

If unable to reach me:

You may leave a detailed message

Please leave a message asking me to return your call

The best time to reach me is (day) _____ between (time) _____

Patient signature:

Date: ____/____/____ Time: _____AM/PM

Special Instructions/Request:

