DIGESTIVE DISEASE GROUP

M.S.Z. BACHINSKI, MD

B.T. GREEN, MD

R. SADURSKI, MD

M.A. MASON, MD

C.A. TURNER, PA-C

K.V. CRAWFORD, NP-C

Authorization for Release of Records

I authorize Digestive Disease Group, P.A. to furnish a copy of the medical records of

_____ DOB _____

to the below named Physician.

I release Digestive Disease Group, P.A. from all legal responsibility of liability that may arise from this authorization.

Physician:	
Address:	
Phone No:	
Fax No:	

_____

Signature

_____

Witness

_____

Date Signed