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

Physician:	
Address:	
Phone No:	
Fax No:	

I authorize the above named physician to furnish a copy of the medical records of

_____ DOB _____

to Digestive Disease Group, PA.

I release you from all legal responsibility of liability that may arise from this authorization.

Fax Records to 864-227-6116

_____

Signature

_____

Witness

_____

Date Signed

103 LINER DRIVE ◆ GREENWOOD, SOUTH CAROLINA 29646-2311 ◆ 864-227-3636