Gastro Consultants of Atlanta, P.C.

Specialists in Digestive and Liver Diseases
Alan M. Fixelle, M.D., F.A.C.G.
www.gastroconsultantsatlanta.com

Authorization for Use or Disclosure of Protected Health Information

PATIENT NAME_____
LAST **FIRST** **MI**

_____
ADDRESS **CITY** **STATE** **ZIP**

DATE OF BIRTH:_____ **PHONE #:**_____

☒ I **authorize Gastroenterology Consultants, P.C. to disclose my protected health information as indicated below to:**

Alan M. Fixelle, MD / Gastro Consultants of Atlanta, P.C.
Name of entity to receive this information

5669 Peachtree Dunwoody Road, Suite 270 Atlanta Georgia 30342
ADDRESS **CITY** **STATE** **ZIP**

404-255-1000 **404-795-5549**
PHONE NUMBER **FAX NUMBER**

Description of Information to be released

☐ I authorize the release my **complete medical** record from: 10/01/2009 to 11/01/2019 to the entity listed above.

-OR-

☐ I authorize the release of limited portions of my medical record as described below to the entity listed above.

INFORMATION TO BE RELEASED:	**PURPOSE OF DISCLOSURE:**
☐ From & To Dates: 10/01/2009 to 11/01/2019	☐ Changing physicians
☐ History and physical exam	☒ Continuing care
☐ Office notes	☐ At patient request
☐ Procedure reports	☐ Second opinion
☐ Lab reports	☐ Legal
☐ Chart messages	☐ Insurance/Workers' Compensation
☐ Medication records	☐ School
☐ Nurse notes	☐ Other: _____
☐ Demographic information	
☐ Other: _____	

I understand that this will include information relating to (check and initial, if applicable):
☐ _____ Acquired immunodeficiency syndrome (AIDS) ; human immunodeficiency virus (HIV) infection
☐ _____ Behavioral health service / psychiatric care ☐ _____ Treatment for alcohol and/or drug abuse

I understand that this authorization will expire 1(one) year from the date signed.

I understand that I may revoke this authorization at any time by notifying (PRACTICE) in writing. This authorization will cease to be effective on the date notified except to the extent that the Practice has acted in trust upon this authorization.

_____ _____
Signature of Patient or Legal Guardian Date

C Effective 09-18-19