GASTROENTEROLOGY CONSULTANTS, P.C.
ALAN M. FIXELLE, M.D., F.A.C.G.

Digestive & Liver Diseases
Diagnostic & Therapeutic Gastrointestinal Endoscopy

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Suite 270
Atlanta, Georgia 30342

Alpharetta Office
3330 Preston Ridge Road
Suite 220
Alpharetta, Georgia 30005

DATE: _____

TO: _____

_____

_____

Patient Name: _____
Patient Date of Birth: _____

Our practice is presently providing medical services to the above named patient. Please submit copies of any **clinical notes, discharge summaries, operative notes, laboratory, pathology and/or radiology reports** on file in your office. Thank you for your prompt assistance.

Alan M. Fixelle, M.D.

MEDICAL RECORDS RELEASE AUTHORIZATION

I, _____,

Social Security #_____

Date of Birth_____ authorize the release of any medical information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS confidential information, necessary to process insurance claims or any medical information that is needed for any utilization review or quality assurance activities. I understand that this information is of a confidential nature and that the insurance carrier may review these documents.

_____ _____
Signature of Person Giving Consent Date

Relationship [if not patient]: _____

Patient unable to sign due to: _____