Alabama Digestive Diseases

Release of Information to ADD

RICHARD T. MCGLAUGHLIN, M.D. | **SHELLEY MORELAND, FNP-C**

TO: _____

_____

_____

I hereby authorize and request that you release the complete history records in your possession concerning my prior treatment to:
Alabama Digestive Diseases, P.C.

Patient's Name: _____

Address: _____

_____

_____

Date of Birth _____

Patient's Signature _____
(If relative, state relationship)

Witness _____ Date _____

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