

Gastroenterology & Hepatology Consultants, P.A.

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_____	_____
(Patient Full Name)	(Birth Date: Month/Day/Year)
_____	_____
(Street Address)	(Social Security Number)
_____	_____
(City, State, Zip Code)	(Phone)

I _____, do hereby authorize the following facility to release my medical information:
(Patient's Name)

_____	_____	_____
(Name of Facility)	(Street Address)	(City, State, Zip)

Dates:	
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Pathology Reports
<input type="checkbox"/> Emergency Reports	<input type="checkbox"/> History and Physical
<input type="checkbox"/> Laboratory Reports	<input type="checkbox"/> Progress Notes
<input type="checkbox"/> Operative Notes	<input type="checkbox"/> Radiology Reports
Other:	

I do I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

Information Release To: _____
Name of Company/Agency/Facility/Person

Street Address

City, State, Zip

Purpose of Disclosure: Discharge Summary Insurance Personal Change of Doctor
 Legal Investigation Disability Determination Continuing Care
 Workers Comp Other:

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____	_____
Signature of individual or guardian or personal representative of patient's estate	Date
_____	_____
Witness (Must be witnessed by an employee or notarized)	Date