Gastroenterology & Hepatology Consultants, P.A.

2301 Rexwoods Dr. Suite 100
Raleigh, NC 27607

10540 Ligon Mill Road
Wake Forest, NC 27587

113 Jolly Street
Louisburg, NC 27549

742 McKnight Dr. Suite 130
Knightdale, NC 27545

Phone: 919-554-6253 **Fax: 919-554-3777**

______________________________ **(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:

___ **Discharge Summary**	___ **Pathology Reports**
___ **Emergency Reports**	___ **History and Physical**
___ **Laboratory Reports**	___ **Progress Notes**
___ **Operative Notes**	___ **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