CENTER FOR DIGESTIVE MEDICINE, PLLC
AUTHORIZATION OF RELEASE OF MEDICAL INFORMATION

PATIENT INFORMATION

Last Name _____ First Name _____ Middle Name _____

Address _____ City State _____ Zip _____

Date of Birth _____ Social Security Number _____ Phone Number _____

I AM REQUESTING MY RECORDS FROM: _____

Address _____ City State _____ Zip _____

SEND COPIES TO: Name _____

Address _____ City State _____ Zip _____

Note: To receive records electronically, please initial here: _____

INFORMATION NEEDED: All pertinent information will be sent along with the following:

Face Sheet	Lab Reports	H & P	X-Ray Reports
Discharge Summary	Test Reports	Operative Reports	Therapy Reports
Pathology Reports	Emergency Reports	Consultation Reports	

Other: _____

This consent will expire ninety (90) days after the date below, or sooner by my choice this consent will expire on: _____

I hereby authorize _____

to release the medical information stated above for the reason and time specified.
I give permission to release information concerning treatment, diagnosis or testing of drug or alcohol abuse, drug related conditions, alcoholism, psychiatric/psychological conditions, Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), test for antibodies to the AIDS virus (HIV), and any hepatic testing such as Hepatitis A, B and or C.

X _____ _____ _____
Patient / Guardian Signature Date Witness

CENTER FOR DIGESTIVE MEDICINE
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