South Oakland
Gastroenterology Associates
Board Certified in Gastroenterology and Internal Medicine

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RELEASE OF INFORMATION AUTHORIZATION

(PLEASE PRINT)

Patient: _____

Address: _____

Social Security No: _____ D.O.B.: _____

PERMISSION IS HEREBY GIVEN TO:

DR._____

_____

_____

_____

TO DISCLOSE RECORDS TO:

DR._____

_____

_____

_____

Including records for treatment and/or mental treatment of chemical dependency and/or alcohol testing or treatment of any communicable or infectious disease, such as Acquired Immunodeficiency syndrome (AIDS); Human Immunodeficiency Virus (HIV); Acquired Immunodeficiency Complex; Venereal Disease; Tuberculosis; Hepatitis, TYPES OF INFORMATION TO BE RELEASED:

___ENDO REPORTS	___LAB'S	___XRAY REPORT	___OFFICE NOTES
___EGD	___PATHOLOGY	___MRI REPORT	___PROGRESS NOTES
___COLONOSCOPY		___CT SCAN REPORT	___MEDICATION LIST
___ERCP		___ULTRASOUND	___GICONSULT
___OTHER		___DISCHARGE SUMMARY	___OTHER CONSULT

PURPOSE OR NEED FOR DISCLOSURE: _____

_____

_____

I understand this consent may be revoked by me at any time by written notice unless the revocation has been received after the records have been released. This authorization will expire ninety (90) days from the date signed unless otherwise specified below:

Date, event, and/or condition: _____

Signature of patient/parent or legal guardian *If legal guardian, a copy of a court order must be attached

Date: _____ Witness: _____ Date: _____

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