



CONSULTANTS IN  
**GASTROENTEROLOGY**<sup>INC</sup>  
 7530 Fredle Drive  
 Concord Township, Ohio 44077  
 (440)386-2250 Phone  
 (440)386-2251 Fax

**AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION  
 FROM CONSULTANTS IN GASTROENTEROLOGY, INC.**

**Name:** \_\_\_\_\_ **SS#:** \_\_\_\_\_

**Phone#:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Reason for Disclosure:** \_\_\_\_\_

**Release Medical Information to:**

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone #:** \_\_\_\_\_ **Fax #:** \_\_\_\_\_

I hereby authorize **Consultants in Gastroenterology, Inc.** to release the health information that is contained in my patient records, including outside Physician's records to:

\_\_\_\_\_

I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse and or HIV/AIDS test results or diagnoses. This authorization does not include permission to release patient psychotherapy notes.

This consent is subject to revocation any time except to the extent the action has already been taken thereon.

\_\_\_\_\_  
**Signature of Patient/Patient's Representative\***

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Relationship if not Patient**

\*If other than Patient's signature, a copy of legal paperwork verifying the Patient's personal representative **MUST** accompany the request(i.e. court appointed guardian, durable power of attorney for health care). For a deceased patient: A death certificate with executor or administrator of estate paperwork must accompany authorization. Exception: parent signing for Patient under the age of 18.