



CONSULTANTS IN
GASTROENTEROLOGY^{INC}
 5900 Landerbrook Drive #190
 Mayfield Heights, Ohio 44124
 (440)461-2550 Phone
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**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 diagnosis. This authorization does not include permission to release patient psychotherapy notes.

This consent is subject to revocation at 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.