RELEASE OF MEDICAL INFORMATION

In the event that I may be unable and/or unavailable to receive information relative to my medical condition(s), until further notice, I hereby authorize CONSULTANTS IN GASTROENTEROLOGY, INC. to release and to discuss medical information with

1. _____ _____ _____
   name relationship phone number

2. _____ _____ _____
   name relationship phone number

3. _____ _____ _____
   name relationship phone number

I authorize CONSULTANTS IN GASTROENTEROLOGY, INC. to view my prescription history from external sources _____ Yes _____ No

May we call you at home? _____ Yes _____ No

May we call you at work? _____ Yes _____ No

May we call your cell phone? _____ Yes _____ No

If you are not home:

May we leave a message with any household member? _____ Yes _____ No

If not, please comment _____

May we leave a message on your answering machine or voicemail? _____ Yes _____ No

_____
Signature

_____
Name (print)

_____
Date of birth

Power of Attorney (if applicable)

_____ _____ _____
name relationship phone number

2/4/11