Gastroenterologists Ltd.

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Authorization to Release Medical Records

I hereby authorize _____ to release medical records and data pertaining to:

Patient Name:	**Social Security Number:**
Street Address:	**Date of Birth:**
City, State, Zip Code:	**Phone Number:**

Please specify what records you are authorizing to be released:

- ☐ All records
- ☐ All records between the dates of _____ and _____.
- ☐ Records pertaining to _____.

Please specify method of release:

- ☐ Pick-up
- ☐ Fax : _____
- ☐ Mail to:

Name:	**Title/Business:**
Street Address:	**Phone Number:**
City, State, Zip Code:	**Relationship to Patient:**

I authorize the use of a copy (including electronic copy) of this form for the disclosure of information described above. I understand that I have the right to revoke this authorization at any time and that such revocation must be in writing. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand that any disclosure of information carries the potential for re-disclosure and the information would be no longer be protected by the federal privacy rules. This authorization expires 12 months from the date that I have signed below.

Patient/Guardian Signature: _____ Date: _____

Office use only:

Completed By: _____

Date Records Picked-up/Mailed: _____