DIGESTIVE AND LIVER SPECIALISTS

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Date Requested: ________________ **Date Sent:** __________

Patient Information

Patient' Name: ____ Date of Birth: __________

Address: ____

City/State/Zip Code: ______________________________________

Telephone Number: ____________________Email Address: ____________________

Release Information

I authorize Digestive and Livers Specialists to release my medical information to:

Name of Provider or Facility: ____________________________________

Address: ____

City/State/Zip Code: ____

Telephone #: _____________________ Fax# : ________________

I Understand That

I may cancel this authorization at any time by submitting a written request to the Practice

The records released may include information regarding mental health, drug or alcohol use/abuse

There may be a charge for the requested records.

____ __________________

Patient/Representative Signature: Date:

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Relationship to Patient (if requester is not the patient)