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:

_____

Relationship to Patient (if requester is not the patient)