AUTHORIZATION TO RELEASE CONFIDENTIAL MEDICAL RECORDS

This form gives us permission to send or receive copies of your medical records.

GI Physician: Angela Shannon, MD

Patient Name: _____ Date of Birth: _____

Address: _____

Phone: _____

I, the undersigned, hereby authorize Happy Tummies Pediatric GI Clinic to release or receive the information described below:
(Check all that apply)

_____ All records _____Lab Reports _____Operative Report(s)

_____Discharge Summary _____Radiology/X-ray Reports _____Consultation Report(s)

_____Endoscopy Report(s) _____H & P Report(s) _____Other_____

Reason for Release:

_____Treatment/Management _____Patient requests for own use _____Moving

_____Changing Doctors _____Claiming Social Security benefits _____Other_____

Check One:

_____ Release TO Happy Tummies Name/Clinic (where records are currently held)_____

_____ Release FROM Happy Tummies Street Address_____

City, State, Zip_____

Phone_____ Fax_____

I understand that this authorization authorizes the release of all medical records including psychiatric, alcohol, drug abuse, and HIV/AIDS records. The use of this information may be protected by Public Law 93-255, Section 408; Public Law 93-282, Section 333; or Federal Regulation 42 CFR, Part 2. The information provided is confidential and any disclosure by the recipients is prohibited.

_____ _____

Patient or Legal Representative Signature Date Signed

_____ ***VOID 1 YEAR FROM DATE SIGNED***

Patient or Legal Representative Print Name

Relationship of Legal Representative: *(Check One)*

_____Parent ____Legal Guardian _____Power of Attorney-Health _____Other_____

THIS FORM MUST BE WITNESSED

Witness Signature_____ Witness Print Name_____