South Oakland GASTROENTEROLOGY associates

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RELEASE OF INFORMATION AUTHORIZATION

Patient: _____ DOB: _____/_____/_____

Last Four Digits of Social Security #_____ Phone #: _____

Address: _____

☐ I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. The information may be released to:

Name: _____ Phone: _____ Fax: _____

Name: _____ Phone: _____ Fax: _____

☐ I authorize that records to be released for the purpose of continuation of care to South Oakland Gastroenterology Associates. (Please check records to be released)

☐ ALL
☐ ENDO
☐ PATH
☐ OFFICE NOTES
☐ LABS
☐ X-RAY
☐ CT/MRI
☐ HOSPITAL REPORTS
☐ OTHER _____

Physician: _____ Phone: _____ Fax: _____

Physician: _____ Phone: _____ Fax: _____

I understand that this **Release of Information** may be revoked by me at any time by written notice unless the revocation has been received after the records have been released.

Signature: _____ Date: _____

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