ADVANCED GASTROENTEROLOGY
"DR. B. JEFFREY WALLIS MD PA"

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

*PATIENT NAME (PRINT):*_____

*ADDRESS:*_____ *CITY, STATE, ZIP:*_____

*DATE OF BIRTH:*_____ *SOCIAL SECURITY NUMBER:*_____

I authorize Advanced Gastroenterology to obtain/release my individual identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

I hereby authorize the release of my individually identifiable health information as listed below:

_____

NAME OF PERSON/ORGANIZATION RECEIVING THIS INFORMATION

_____

ADDRESS *CITY, STATE, ZIP*

_____

PHONE *FAX*

_____

NAME OF PERSON/ORGANIZATION SENDING THIS INFORMATION

_____

ADDRESS *CITY, STATE, ZIP*

_____

PHONE *FAX*

_____***PLEASE RELEASE A COPY OF MY MEDICAL RECORD FOR THE DATES OF:*** _____
_____***PLEASE RELEASE MY ENTIRE MEDICAL RECORD***
_____***PLEASE RELEASE SPECIFIC INFORMATION ONLY FROM MY MEDICAL RECORD:***_____
_____
_____ ***OTHER (PLEASE SPECIFY):***_____
_____

PURPOSE OF DISCLOSURE: _____***CONTINUITY OF CARE*** _____***OTHER***

*PATIENT SIGNATURE:*_____ *DATE:*_____