Ohio Gastroenterology & Liver Institute

AUTHORIZATION OF RELEASE OF MEDICAL INFORMATION

PATIENT INFORMATION

Last Name:_____

First Name:_____

DOB:_____

Phone #:_____

COPIES SENT FROM:_____

COPIES SENT TO: MICHAEL D KREINES, MD 2925 VERNON PL 100# CIN, OH 45219 FAX: (513) 872-4553

INFORMATION NEEDED:

FACE SHEET	**LAB REPORTS**
OP REPORTS	**X-RAY REPORTS**
PATH REPORTS	**H & P**
CONSULT REPORTS	**OTHER:_____**

REASON NEEDED: Medical_____ Disability_____Insurance_____Legal_____

This consent will expire sixty (60) days after the date below, or sooner by my choice this consent will expire on :_____

I hereby authorize_____
to release the medical information stated above for the reason and time specified.
I give permission to release information concerning treatment, diagnosis, or testing of drug or alcohol abuse, drug related conditions, psychiatric/psychological conditions, AIDS, HIV, and hepatic testing.

_____

PATIENT/GUARDIAN SIGNATURE **DATE** **WITNESS**