Ohio Gastroenterology and Liver Institute

AUTHORIZATION OF RELEASE OF MEDICAL INFORMATION

PATIENT INFORMATION

Last Name First Name Middle Name

Address City State Zip

Date of Birth Social Security Number Phone Number

I AM REQUESTING MY RECORDS FROM: _____

Address City State Zip

SEND COPIES TO:

Name

Address City State Zip

Note: To receive records electronically, please indicate here: ☐

INFORMATION NEEDED: All pertinent information will be sent along with the following:

Face Sheet	Lab Reports
H & P	X-Ray Reports
Discharge Summary	Test Reports
Operative Reports	Therapy Reports
Pathology Reports	Emergency Reports
Consultation Reports	Other: _____

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, alcoholism, psychiatric/psychological conditions, Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), test for antibodies to the AIDS virus (HIV), and any hepatic testing such as Hepatitis A, B and or C.

X

Patient / Guardian Signature Date Witness

OHIO GI & LIVER INSTITUTE
2925 Vernon Place, Ste 100
Cincinnati, OH 45219
ATTN: MEDICAL RECORDS
FAX: 513-872-4553