Gastro Health (Formerly 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
H & P
Discharge Summary
Operative Reports
Pathology Reports
Consultation Reports
Lab Reports
X-Ray Reports
Test Reports
Therapy Reports
Emergency 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

Gastro Health
2925 Vernon Pl., Suite 100,Cincinnati, OH 45219
ATTN: MEDICAL RECORDS
FAX: 513-872-4553