SOUTHWEST GASTROENTEROLOGY ASSOCIATES

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THERESA MELDON C.R.N.P.

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AUTHORIZATION FOR RELEASE OF PROTECTED INFORMATION

This Authorization MUST be signed by the patient. If the patient is under 18 years of age, legally incompetent or is unable to sign the parent/guardian or authorized representative.

Patient Name:_____ Date of Birth:_____

Address:_____ Social Security #:_____

City:_____ Phone #:_____

State:_____ Zip Code:_____ Maiden Name/if applicable:_____

I HEREBY AUTHORIZE SOUTHWEST GASTROENTEROLOGY ASSOCIATES TO:

(CHECK ONE THAT APPLIES)

☐ RELEASE TO *OR* ☐ OBTAIN FROM

PARTY TO RELEASE / RECEIVE THE ABOVE NAMED INDIVIDUAL'S HEALTH INFORMATION:

Name:_____

Address:_____

FAX #_____

THE REQUESTED DOCUMENTATION OR COPIES OF THE FOLLOWING ARE REQUESTED: *(PLEASE CHECK ALL RECORDS DESIRED*

___ DISCHARGE SUMMARY ___OPERATIVE REPORTS ___ HISTORY AND PHYSICAL

___ CONSULTATION ___ PROGRESS NOTES ___ EMERGENCY DEPT. RECORDS

___ RADIOLOGY REPORTS (SPECIFY) _____

___The above information and/or the entire clinical record which includes HIV related information, mental health, drug or alcohol treatment

___The entire clinical record excluding HIV related, mental health, drug or alcohol treatment

___ OTHER (SPECIFY) _____

FROM (DATE):_____

*THIS INFORMATION WILL BE USED FOR THE FOLLOWING PURPOSE:*_____

- I MAY REVOKE THIS AUTHORIZATION AT ANYTIME BY SUBMITTING A WRITTEN NOTICE TO THE MEDICAL RECORDS DEPT. AT SOUTHWEST GASTROENTEROLOGY ASSOCIATES. I UNDERSTAND THAT THIS NOTICE CANNOT BE REVOKED IF RECORDS HAVE ALREADY BEEN RELEASED.
- THIS AUTHORIZATION WILL EXPIRE IN 6 MONTHS FROM THE DATE OF THE PATIENT OR AUTHORIZED REPRESENTATIVE'S SIGNATURE

_____ _____

PATIENT OR REPRESENTATIVE SIGNATURE DATE

_____ _____

REPRESENTATIVES SIGNATURE (IF NOT THE PATIENT) RELATIONSHIP TO PATIENT