

Consultants In Gastroenterology, L.L.C.

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MEDICAL RECORDS RELEASE REQUEST FORM

I authorize the release of the following medical information:

_____ most recent office visit/H&P

_____ Last year of reports

_____ X-ray reports

_____ X-ray films

_____ Lab

_____ Surgical Reports

_____ EKG

_____ Entire Chart

I request that my medical records from:

(Physician Name)

(Physician Address)

(Physician Phone # and Fax #)

Be sent to:

(Physician Name)

(Physician Address)

(Physician Phone # and Fax #)

Regarding:

(Patient Name)

(Patient Date of Birth)

(Patient Address and Phone #)

Patient Signature: _____ Date: _____

Physician's Initials/Approval: _____ Date: _____

Records Sent by: _____ Date: _____