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HEALTH INFORMATION RELEASE FORM

In order that we may serve you more efficiently, please fill out the following information.

I________________________ give permission for Hattiesburg GI Associates, PLLC and Digestive Diseases Center of Hattiesburg to share my health information with the following people who are involved in my care:

Name	Relationship	Contact Number
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________

______________________________ Patient Signature

______________________ Date of Birth

______________________________ Print Name

______________________ Date

Office Use Only

______________ Chart Number

______________ Patient

Entered into gGastro by: ______________________ Print Name ______________ Date