GASTROENTEROLOGY GROUP, INC.

RELEASE OF PRIVATE HEALTH INFORMATION AUTHORIZATION

Patient Name: _____ Date of Birth: _____

Please list any individuals you would like us to be able to share your information with; other than your referring physician. (For example: a family member)

_____

_____

_____

_____

Please choose **ONE**:

_____ Medical Health Information (including STD, HIV, Hepatitis)

_____ Medical Health Information (except STD, HIV, Hepatitis)

Can we share financial/billing information? (circle) YES NO

This authorization is valid as long as I am a patient here?

YES NO (date if no)_____

Signature: _____ Date: _____

Witness: _____ Date: _____