# AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

To: CENTER FOR GASTROINTESTINAL DISORDERS, INC.
112 La Casa Via, Suite 320 Walnut Creek, CA 94598
Phone: (925) 939 5599 Fax: (925) 939 4099

From (patient): ________________________________ DOB:______________
or Guardian:______________________________________________________

I hereby request you to release the following medical records to:

Dr.:_____________________________________________________________
Address__________________________________________________________
_________________________________________________________________
_________________________________________________________________

**Fax :**_(____)_________________ Telephone: _(____)____________________

Requested Records:

___ Endoscopy ___ Colonoscopy ___ Pathology

___ UGI series ___ Barium enema ___ Barium swallow

___ CT scan ___ PET scan ___ Ultrasound

Others:__________________________________________________________

Laboratory tests:__________________________________________________

Date of request:___________________________________________________

Patient's/Guardian's signature:_________________________________________

*NOTICE: THIS FAX CONTAINS CONFIDENTIAL INFORMATION*

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