AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

To the office of Dr.____

From (patient):________________________________ DOB:______________

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

S. SAEED ZAMANI, M.D.
Center for Gastrointestinal Disorders, Inc.
112 La Casa Via, Suite 320
Walnut Creek, CA 94598

Phone: (925) 939 5599
Fax: (925) 939 4099

Requested Records:

___ CT scan	___ Ultrasound	___ BA Swallow
___ UGI series	___ Ba. Enema	___ Consultation report
___ MRI	___ PET scan	___ Pathology
___ Endoscopy	___ Colonoscopy	___ ERCP

Laboratory tests:____

Others____

Date of request:______________________________

Patient's signature:___________________________

NOTICE: THIS FAX CONTAINS CONFIDENTIAL INFORMATION
This fax is intended for the use of individual or entity to whom it is addressed, and may contain information that is privileged, confidential and exempt from disclosure under applicable law. If you are not the intended recipient, distribution or copying of this communication is strictly prohibited. If you have received this communication by error, please notify our office immediately.