AUTHORIZATION FOR RELEASE OF MEDICAL/HEALTH INFORMATION

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 give permission to you to release or discuss my Medical/Health information to:

Name: _____ Relation: _____

Address_____
_____
_____

Telephone: (____) _____ Fax : (____)_____

I will notify you in writing if I decide to withdraw this permission in the future.

Date of request: _____

Patient's/Guardian's signature:_____