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AUTHORIZATION TO RELEASE RECORDS TO OTHER PHSICIANS

I hereby authorize the release of pertinent medical information from Northeast Gastroenterology Associates, P.C. To the following physicians and or family members whom also participate in my medical care. I realize this information can not be sent without my explicit consent. By signing below, I therefore give my consent for records to be released.

AUTHORIZATION TO RELEASE MEDICAL RECORDS TO OTHER PHYSICIANS

NAME SPECIALITY
PHONE

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AUTHORIZATION TO RELEASE MEDICAL RECORDS TO FAMILY/FRIENDS /CAREGIVERS

NAME RELATIONSHIP
PHONE

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THIS CONSENT DOES NOT PERTAIN TO THE FOLLOWING CATERGORIES WITHOUT MY SPECIFIC AUTHORIZATION IN THE SPACE BELOW. PLEASE CIRCLE EACH CATERGORY THAT YOU **DO NOT WISH TO HAVE RELEASED.**

ABORTION AIDS/ARC HIV TESTING INFERTILITY STUDIES

VENEREAL DISEASE SEXUAL ASSAULT DRUG/ALCHOL ABUSE

MENTAL HEALTH

Signed: _____ Date: _____