Authorization for Release of Confidential Medical Information

Estrella Gastroenterology

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Patient Name:_____DOB:_____

Previous Maiden Name: _____Phone #_____

Release my medical/health information to the following physicians, hospitals, facilities or Self:

Name:_____Ph:_____F:_____

Name:_____Ph:_____F:_____

Name:_____Ph:_____F:_____

Information to be released:

✓ **Colonoscopy, EGD, and Pathology Reports**

- ☐ CT scans, Ultrasounds, and or any GI imaging
- ☐ Labs/Stool test
- ☐ Liver Biopsy
- ☐ Surgical report and Pathology:_____
- ☐ Other_____

Exclude HIV/AIDS; STD; and Psychiatric disclosures unless specifically authorized.

This information is for the treating specialist and continuation of care and should not be used for any other purpose. I understand that I may withdraw this consent at any time in writing except to the extent that action has been taken in reliance on it. This consent will last while I am being treated by *Estrella Gastroenterology* unless I withdraw my consent during treatment. This consent will expire 365 days after my last visit, unless *Estrella Gastroenterology* is otherwise notified by me.
I authorize Estrella Gastroenterology at the above address to release my medical history information.

_____ _____
Patient Signature Date

_____ _____ _____
POA/Legal Guardian (Print Name/Relation) POA/Legal Guardian (Signature) Date