Authorization for Release of Confidential Medical Information

Release to:

Estrella Gastroenterology
Shahab Aftahi, MD
Stephanie Wolz, FNP
13065 W. McDowell Rd. Suite C-105
Avondale, AZ 85392
Phone: (623)935-4056
Fax: (623)935-2018

Patient Name:____DOB:_______________

Previous Maiden Name: ____Phone #___________________

Receive my medical/health information from the following physicians, hospitals or facilities:

Name:____Ph:____________________F:___________________

Name:____Ph:____________________F:___________________

Name:____Ph:____________________F:___________________

Information to be released:

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

Or the following Items:

☐ 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 obtain and receive my medical history information.**

___________________________________ ______________________
Patient Signature Date

___________________________________ ____________________________ __________
POA/Legal Guardian (Print Name/Relation) POA/Legal Guardian (Signature) Date