West Gastroenterology Medical Group

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AUTHORIZATION REQUEST FOR RELEASE OF MEDICAL RECORDS

DATE: _____

FACILITY: _____

PHONE: (____) ____ - ____ FAX: (____) ____ - ____

- ☐ Consultation
- ☐ Discharge Summary
- ☐ Procedures / Pathologies
- ☐ Labs
- ☐ Ultrasounds / MRI's / CT Scans
- ☐ Other: _____

I, THE UNDERSIGNED, HEREBY AUTHORIZE AND REQUEST YOU TO FURNISH WEST GASTROENTEROLOGY MEDICAL GROUP WITH COPIES OF ANY AND ALL MEDICAL INFORMATION, HISTORY, RECORDS, AND DIAGNOSES IN YOUR POSESSION RELATING TO SERVICES RENDERED. THANK YOU FOR YOUR PROMPT ATTENTION!

PATIENT NAME: _____ DATE OF BIRTH: _____

SIGNATURE: _____

PATIENT OR GUARDIAN IF PATIENT UNABLE TO SIGN