



ASHEVILLE GASTROENTEROLOGY ASSOCIATES
(A Division of Digestive Health Partners)
191 Biltmore Avenue, Asheville, NC 28801
Telephone: 828-254-0881 Fax: 828-258-1614

AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

Patient's Name: Patient's Date of Birth:
Patient's Address: Last 4 digits of SSN:
City/State/Zip: Day Phone:

I do hereby consent and authorize: ASHEVILLE GASTROENTEROLOGY ASSOCIATES (a Division of Digestive Health Partners)
191 Biltmore Avenue, Asheville, NC 28801
Phone: (828)-254-0881 (Fax) 828-258-1614

FOR OFFICE USE:

To release To obtain

My medical records to/from:

Provider/Organization Name:
Address:
City/State/Zip:
Phone: Fax:

Information to be released (Please provide a specific description of the information to be released):

Lab Results MD/PA Consults Procedures Pathology
Follow-Up Other:

Note: By signing this authorization, you acknowledge that it extends to all or any part of the records designated above, which may include psychiatric information, HIV test results, alcohol/drug abuse, etc., unless specifically excluded by you.

I understand that this authorization will expire on (please provide date or specify "no expiration"):

Signature of Patient Date

Parent/Legal Guardian/Authorized Person Date

Notice to Patients: The patient or the patient's representative may inspect and/or copy the health information to be used or disclosed in accordance with practice policies. You may refuse to sign this authorization or revoke it in writing at a later date if the information has not already been disclosed. We will not condition treatment or payment on your providing this authorization except in the specific circumstances allowed by the HIPPA Privacy Rule. We cannot protect against the possibility that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by law.