DIGESTIVECareNY
GASTROENTEROLOGY, LIVER & PANCREATIC DISEASE

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REQUEST FOR RELEASE OF MEDICAL INFORMATION

Patient's Name: _____ Date of Birth: ____/____/____

To: _____ Today's Date: ____/____/____

Address:
_____

This will authorize and request that you forward information regarding the examination, diagnosis and treatment of the above named patient. The following are of special interest:

☐ History and Physical Exam
☐ Consultations
☐ Progress Notes
☐Operative/Procedure Reports
☐ Pathology Reports
☐ Other: _____

Request further information on file regarding:

Time period of Inquiry: _____

Special Qualification by the patient limiting authorization:

_____ _____
Signature Print Name