Newport Coast Gastroenterology
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Authorization for release of Medical Records

Patient Name: _____

DOB: _____

Phone: _____

Fax: _____

I request and authorize the release of my information and medical records concerning my history, treatment, examinations and/or hospitalizations to:

Name: _____

Address: _____

Phone: _____ **Fax:** _____

I understand that this form does NOT authorize the release of any medical information concerning HIV test results and/or treatments, sexually transmitted diseases, psychiatric care, psychological assessment and/or treatment, drug or alcohol abuse treatment or pregnancy termination.
I understand that the release or transfer of the information specified above to any person or entity not specified is prohibited.

_____ _____

Signature of Patient Date

_____

Signature of patient's Legal Representative (if applicable)

_____

Legal Representative's relationship to patient