AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Name:_____

Date of Birth:_____ Today's Date:_____

❑ RECORDS TO MODESTO GASTROENTEROLOGY MEDICAL CORP. :

I hereby authorize:

_____
Physician's Name

Modesto Gastroenterology Medical Corp.
2336 Sylvan Ave., Ste. A
Modesto, CA 95355
Phn: (209) 338-0292
Fax: (209) 338-0298

The release of Medical Records in your possession as specified below:

- ❑ All Medical Records
- ❑ Specific Date(s):
  From: _____ To: _____
- ❑ Other: _____

_____

❑ RECORDS FROM MODESTO GASTROENTEROLOGY MEDICAL CORP. :

I hereby authorize:

Modesto Gastroenterology Medical Corp.
2336 Sylvan Ave., Ste. A
Modesto, CA 95355
Phn: (209) 338-0292
Fax: (209) 338-0298

To release to:

_____
Physician's Name

_____
Physician's Address

_____
City, State, ZIP

The Medical Records in our possession as specified below:

- ❑ All Medical Records
- ❑ Specific Date(s):
  From: _____ To: _____
- ❑ Other: _____

_____

_____ _____
Signature of Patient Signature of Witness