Sent to:_____ Date:_____

Philadelphia Gastroenterology Consultants, Ltd.

Authorization for Release of Information

I hereby authorize Philadelphia Gastroenterology Consultants, LTD to obtain the following information: any medical records or other information regarding my treatment, hospitalization, and/or outpatient care for my impairment(s), Hepatitis C, drug abuse, alcoholism, or human immunodeficiency virus (HIV) infection, including acquired immunodeficiency syndrome (AIDS), or testing for HIV; from the health record(s) of:

Patient Name:_____ D.O.B. _____ MR#: _____

Hospital Adm. Date: _____ D/C Date: _____

Hospital Out-pt. Date: _____ ED Date: _____

Information to be released (Check all that apply):

(__) Discharge Summary (__) Radiology Report

(__) History & Physical (__) Operative Report

(__) Laboratory report (__) Pathology Report

(__) Consultation Report (__) All GI Records

(__) Emergency Record (__) All of the above

(__) Other (Specify): _____

Please fax above records to 215-742-7051 as soon as possible.

I understand this consent can be revoked at any time except to the extent that disclosure has already occurred in reliance on this request. Otherwise, this authorization shall remain in effect indefinitely, unless specified by the patient or parent-legal guardian.

_____, _____ _____, _____

Signature of Patient Date Signature of Parent-Legal Guardian Date

_____, _____

Requesting Provider Staff Initials

700 Cottman Avenue ♦ Bldg. B Suite 201 ♦ Philadelphia, PA 19111
Phone: (215) 742-9900 ♦ Fax: (215) 742-7051 ♦ Website: www.pgcdocs.com