1429 N. Mount Auburn Rd * Cape Girardeau, MO 63701
Phone: (573) 334-8870 * Fax: (573) 334-7340

Consent for the Release of Confidential Information

Patient Name: ______________________ SSN: ______________ DOB: ________ Sex: ____

Address: ______________________ City/State: ______________________ Zip: ________

Attending Doctor: ______________________ Patient Phone: ______________________

I (We), the undersigned, ______________________________________, hereby authorize

______________________________________ Fax # ______________________

to release to ***Gastroenterology Associates/GA Endoscopy Center*** any pertinent records or information concerning

myself or ____.
(Relationship) (Name)

The purpose or need for the disclosure of this information is to: ***Transfer of Medical Records***

The extent or nature of information to be disclosed: ______________________________

____

The approximate date of treatment: ______________________________________

This consent authorized the release of information that is considered confidential. It is intended for the use of the specified agent or agency only or such agency to which redisclosure of this information is necessary to accomplish its service. The agent or agency will make no further disclosures of this information without the written consent of the patient to whom it pertains.
In case of records containing information related to drug or alcohol treatment, this confidentiality is protected by federal regulation (32 CFR Part 2). The undersigned may revoke this consent at any time, except to the extent that action has been taken in reliance upon this consent and the undersigned agrees information under the authority of this consent.

The date on which this consent is executed: ______________________________

This consent shall expire on ______________________________ (90 days from date signed)

unless sooner revoked in writing to ***Gastroenterology Associates/GA Endoscopy Center.***

The exception to this consent ______________________________________

And I assume full responsibility for these exceptions.

Patient Signature: ____

The undersigned further states that the matters stated above are true, and that falsification thereof is prohibited by 42 CFR Part 2, section 2.31.

Date ______________________ Time ____________ am/pm or ______________________
(Authorized Person)

Witness ______________________ Relationship to patient ______________________