Center for Digestive Wellness
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(PLEASE PRINT)

PATIENT NAME: _____

DATE OF BIRTH: _____/_____/_____

ADDRESS: _____

PHONE #: _____

I hereby authorize _____ to release the following information.

PLEASE SPECIFY: _____ ALL RECORDS **OR** LIST SPECIFIC RECORDS BEING REQUESTED

_____

_____

_____

DATES OF TREATMENT - FROM: _____ TO: _____

SEND TO: _____

ADDRESS: _____

PHONE: _____

FAX: _____

REASON FOR REQUEST: _____

_____ _____

Patient/person authorized to consent (Signature) Date