NORTHSIDE GASTROENTEROLOGY, INC., P.C.

RELEASE OF INFORMATION

NAME: _____ DATE OF BIRTH: _____

Due to HIPAA rules and regulations, we are not to release any of your medical information including diagnosis or records of any kind unless stated otherwise.

Please list individuals(family/friends) that we may speak with regarding your care:
PLEASE DO NOT LIST ANY PHYSICIANS

1. _____
2. _____
3. _____

If we are unable to reach you:

May we talk to anyone else that might answer? YES NO

May we leave a detailed message? YES NO

Please provide your email address: _____

I hereby authorize the release of any medical information necessary to process any and all of my claims, or facts concerning the treatment provided. I further authorize my insurance company to pay Northside Gastroenterology, Inc., P.C. I understand that I am financially responsible for those charges not paid by my insurance. A photocopy of this authorization shall be considered as valid as the original. **This Release of Information will remain in effect until terminated by the patient in writing.**

Patient Signature: _____ Date: _____/_____/_____