LEHIGH GASTROENTEROLOGY ASSOCIATES LLC

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AUTHORIZATION FOR MEDICAL INFORMATION

Patient: _____ DOB: _____
Address: _____ SS#: _____

Home Phone: _____

I hereby authorize _____ to release the following information.

Dr./Facility Address: _____
P#: _____
F#: _____

Medical Records: _____

For the Dates of Service: _____ to _____

____I Do ____I Do Not authorize the release of information related to Psychiatric care and/ or psychological assessment and/or treatment for Drug/Alcohol Abuse, and/or AIDS(Acquired Immunodeficiency Virus)infection.

Information is to be released to _____

I hereby authorized the disclosure of the above indicated health information for the above stated patient. The authorization is valid for 12 months from the date of signature. I understand that I may cancel this authorization at any time by sending written notice to the provider, Lehigh Gastro. Assoc. Privacy Officer.

_____
Signature of Patient, Guardian or
Personal Representative of the Patient's Estate

Date _____