AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

______________________________	____________________
Name of Patient	Birth Date
______________________________	____________________
Steet Address	Phone Number
______________________________	____________________
City, State, Zip	Social Security #

AUTHORIZES:

Great Lakes Gastroenterology, LLC.
8877 Mentor Avenue
Mentor, Ohio 44060
Phone: 440-205-1225
Fax: 440-205-1275

TO RELEASE PROTECTED HEALTH INFORMATION TO:

Name: ______________________________
Address:______________________________
____
Phone:______________________________
Fax:________________________________

INFORMATION TO BE RELEASED

___ Medical History, Exam, Consultation Reports
___ Treatment or Tests
___ Laboratory and X-ray Reports
___ Prescriptions
___Other
___ Surgical Reports
___ Hospital Records Including Reports
___ Entire Medical Record

FOR THE FOLLOWING DATE(S): ____

PLEASE NOTE: (The medical record may contain information about drug abuse, alcoholism, alcohol abuse, venereal disease, HIV testing and/or AIDS diagnosis treatment, abortion, or mental health treatment. Separate consent must be given before this information can be released).

PURPOSE FOR NEED OF DISCLOSURE:

___ Personal (At the request of the individual)
___ Insurance Eligibility/Benefits
___ Changing Physicians
___ Legal Investigation or Action

____

Signature of patient **Date**

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

______________________________	______________________________
Name of Patient	Birth Date
Steet Address	Phone Number
City, State, Zip	Social Security #

AUTHORIZES

____
(Name of healthcare plan/provider/other)

____
(Street Address)

____
(City, State, and Zip)

TO RELEASE PROTECTED HEALTH INFORMATION TO:

Great Lakes Gastroenterology, LLC
Keith A Friedenberg, MD
Don Brinberg, MD
Sayed Khatami, MD
Keyur Parikh, MD

8877 Mentor Ave, Mentor, OH 44060
PHONE: 440-205-1225
FAX 440-205-1275

INFORMATION TO BE RELEASED

___ Medical History, Exam, Consultation Reports
___ Treatment or Tests
___ Laboratory and X-ray Reports
___ Prescriptions
___ Other____
___ Surgical Reports with biopsy
___ Hospital Records Including Reports
___ Entire Medical Record

FOR THE FOLLOWING DATE(S):____

PLEASE NOTE: (The medical record may contain information about drug abuse, alcoholism, alcohol abuse, venereal disease, HIV testing and/or AIDS diagnosis treatment, abortion, or mental health treatment. Separate consent must be given before this information can be released).

PURPOSE FOR NEED OF DISCLOSURE:

___ Personal (At the request of the individual)
___ Insurance Eligibility/Benefits
___ Further Medical Care
___ Changing Physicians
___ Legal Investigation or Action
___ Other_____________________________

____

Signature of patient **Date**