# 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
Sunil S. Patel, MD

9485 Mentor Ave #105
Mentor, Ohio 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
___ Surgical Reports with biopsy
___ Hospital Records Including Reports
___ Entire Medical Record
___ Other_____

**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**