



# GATEWAY GASTROENTEROLOGY INC.

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## RECORDS RELEASE

TO: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone/Fax: \_\_\_\_\_

I hereby authorize you to release to \_\_\_\_\_  
any information regarding my medical history, including the results of diagnostic studies and treatment.

The following are requested:

- |                                    |                        |
|------------------------------------|------------------------|
| _____ Hospital Admission Summaries | _____ Operative Notes  |
| _____ Hospital Discharge Summaries | _____ X-ray Film       |
| _____ Progress Notes               | _____ X-ray Reports    |
| _____ Nurses Notes                 | _____ Lab Reports      |
| _____ Medication Record Sheets     | _____ Pathology Slides |
| _____ Pathology Reports            | _____ Other _____      |

\_\_\_\_\_  
Patient's Signature

D.O.B. \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_