LAKESIDE GASTROENTEROLOGY

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Release Information From The Following:

Doctor's Name_____ Address_____

Phone:_____ Fax:_____

This letter will authorize you to provide a copy, summary, or narrative of my medical records (as indicated by the check mark(s) below) or to otherwise release confidential information. At this time I am requesting the following:

☐ Complete record (Specify)_____

☐ Records of care from _____ to _____ only

☐ Other. Specify: _____

HIV/AIDS. I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS, with the rest of my medical records.

Initial _____ Date _____

to the following person(s):

_____

Name

_____

Street City State Zip

The reasons or purposes for this release of information are:

_____

Pt's Name:_____ DOB: _____

Patient's SS # _____

Signed:_____Date: _____

(Patient or person legally authorized to consent on patient's behalf)