LAKESIDE GASTROENTEROLOGY
& LIVER SPECIALIST
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PATIENT AUTHORIZATION TO RELEASE

PROTECTED HEALTH INFORMATION TO DESIGNATED REPRESENTATIVE(S)

I,_____, give my authorization to release my protected health information including results of my laboratory tests, X-rays, and/or other test results to the following designated representative(s).

Patient Initials

_____ My Spouse (Name) _____

_____ My Child (Name) _____

_____ Other (Name) _____

_____ Personal Representative _____

_____ May be left on my answering machine at home.

_____ May be left on my answering machine at work.

_____ May be left on my Cell Phone. _____.

_____ MAY NOT BE GIVEN TO ANYONE OTHER THAN MYSELF.

_____ _____
Patient Signature Date

_____ _____
Print Date

As a patient, you have the right to revoke this authorization in writing at any time, except to the extent that action has been taken in reliance in this authorization or, if applicable, during contestability period. In order for the revocation of this authorization to be effective, Lakeside Gastroenterology must receive revocation in writing. The revocation must include, 1) The patients name, address, DOB, 2) The patients desire to revoke the authorization, 3) The date of the revocation and the patients signature. All revocations must be sent tin writing to our office and will not be considered effective until receive by our office. 09/20/2010