Advanced
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CONSENT TO RELEASE INFORMATION

I understand that in order to disclose information relating to my care, Advanced Gastroenterology of Texas must have my consent. Therefore, I authorize the practice to disclose my information as described in the Notice of Privacy Practices to the recipients listed below.

Description of the information to be disclosed (check all that apply)

☐All Procedures ☐Test Results ☐Appointments ☐Other_____

☐Surgeries ☐Billing/Account information

Name(s) of the person(s) authorized to obtain the above mentioned information. (e.g. Physician other than your referring doctor, family members and other specified person/persons)

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

I authorize Advanced Gastroenterology of Texas to contact me at the following number(s) with results or questions and acknowledge if I chose to have my information emailed there is a risk of breach of information.

Home_____Cell_____Work_____

Email_____

Please indicate your preferred method of communication . _____

May we leave a detailed message on your answering machine or voicemail? Yes ☐ No ☐

Please list any restrictions or concerns you have relating to your release of information.

_____

_____

_____ _____

Patient Name Date

_____ _____

Signature of Patient or Guardian Relationship to Patient