



Oak Ridge Gastroenterology Associates, P.C.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____, do hereby give my consent to and authorize Oak Ridge Gastroenterology Associates to release to _____ all medical information contained in my medical record. I hereby release Oak Ridge Gastroenterology Associates from all legal liability that may arise from the release of the information requested. I understand that these records may contain information regarding HIV/Hepatitis testing and/or results of these tests. I understand that this consent is subject to written revocation by me at any time unless an earlier date is specified, that it automatically expires 60 days from the date affixed below.

Date: _____ Signed: _____
Patient

Items Requested: _____

Authorized person other than patient: _____

Relationship to patient: _____

Address to whom records sent: _____

Date Sent: _____

By Whom: _____

Chart #: _____