

**ATHERTON ENDOSCOPY CENTER
MEDICAL RECORDS - RELEASE OF INFORMATION**

Patient Name:		Chart #:	Date:
Name of Institution Holding Records To:			
Address:			
City, State, Zip:			
I AUTHORIZE YOU TO RELEASE RECORDS:			
Name of Person/Institution Requesting Records To:			
Address:			
City, State, Zip:			
REASON FOR RELEASING INFORMATION			
PORTION OF MEDICAL RECORD TO BE RELEASED DATE OF PROCEDURE _____			
Description		Description	Description
Entire Medical Record		Physician's Orders	Nurse's Notes
EKG Report		History & Physical Report	Progress Notes
Lab Report		Discharge Summary	Procedure Record
Pathology Report		Anesthesia Record	HIV/Aids Related Med Hx__
Other:			
<p>This authorization will remain in effect for six months unless otherwise stipulated by the patient. This authorization can be revoked in writing by the patient at any time, but it is not retroactive to release of information made in good faith.</p> <p>This information is released in good faith for a specific purpose. No copies of released information may be disclosed to anyone without additional written consent of the person to whom it pertains, unless specified in this authorization. All information released will be stamped with a statement prohibiting re-disclosure.</p> <p>The undersigned hereby releases the above mentioned institution from any liability which may arise from release and/or examination of the information indicated above. I understand there is a charge for copies and that such charges must be paid prior to the release of records.</p>			
Signature of Patient or Legal Guardian:		Birthdate:	
Address:		Date:	
Printed Name of Person Releasing Records:			
Signature		Date	