Galen Digestive Health
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Authorization to Release Medical Records/Information to Requested Doctor, Facility or Other Party

Patient's name:_____
Social Security Number:_____ Date of Birth:_____

Release records from: ☐ Galen Digestive Health ☐ Other: _____
Release records to: ☐ Galen Digestive Health ☐ Other: _____
Address:_____
City, State & Zip: _____

Release these records:

	Initials
1. Only records generated by this facility (not including records received from other sources)	_____
2. Only some portion of records maintained at facility (dates of treatment, etc. specify below) _____	_____
3. All medical records at this facility	_____

If you do not want certain portions of your medical records released, please read this section carefully and initial the boxes for information you do not want released. Otherwise, your records will be released as specified above.

I authorized the health care provider to release the information specified to the organization, agency, or individual named on this request with the EXCEPTION of:

Initials
_____ Susbstance abuse, if any _____ Psychological or psychiatric conditions, if any
_____ AIDS/HIV, if any _____ Other (please specify) _____

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Expiration or revocation of authorization – I understand that I may revoke this authorization at any time and that unless an earlier date is specified it will automatically expire 12 months after the date affixed below.
Use of copies – A copy of this authorization may be utilized with the same effectiveness as the original.

Patient name (print): Person legally authorized to sign for patient (print):

_____ _____

Patient's signature: Authorized person's signature

_____ or _____

Date: _____ Relationship to patient:_____

Date:_____