ADVANCED GASTROENTEROLOGY

10110 MOLECULAR DRIVE, SUITE 111, ROCKVILLE, MD 20850
P: 301.838.4224 F: 301.838.4244

Ghanshyam Gupta, M.D.
[illegible], PA-C
[illegible], PA-C

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: ______________________________

Previous Name (if any): ______________________________

Patient Date of Birth: ______________________________

I request and authorize Ghanshyam Gupta, M.D., PC to release health care information of the patient named above to:

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This request and authorization applies to:

____ All heath care information

____ Healthcare information relating to the following treatment, condition, or dates: (please list)

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____ Other: (please list)

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The medical records to be released may contain medical information pertaining to psychiatric, drug and/or alcohol diagnosis and treatment. The consent to disclose information may be revoked by me at anytime except to the extent that action has been taken in reliance thereon.

____________________________________ ______________________________

Signature Print Name

____

Relationship to Patient (if not patient, must be legal guardian or have power of attorney)

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Date

____

Witness Signature (for office use only)

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.