**ADVANCED GASTROENTEROLOGY**

10110 MOLECULAR DRIVE, SUITE 111, ROCKVILLE, MD 20850
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Ghanshyam Gupta, M.D

Margaux Gonzalez, 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)

________________________________________________

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 any time 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)

______________________________

Date

______________________________

Witness Signature (for office use only)

**THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.**