GREATER HOUSTON DIGESTIVE DISEASE CONSULTANTS
9200 Pinecroft Dr. Suite 480 • The Woodlands, TX 77380
Phone: 281.205.1111 • Fax: 281.419.2111 • www.GreaterHoustonDDC.com

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: _____

Date of Birth: _____ Social Security#: _____

I request and authorize _____Phone #:_____Fax#:_____
(Name of YOUR Physician)

To release the medical records of the patient named above to:

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9200 Pinecroft Dr. Suite 480
The Woodlands, Texas 77380
Main: 281-205-1111 Fax: 281-419-2111

This request and authorization applies to:
Health Care Information relating to the following treatment, condition or dates of treatment:

___ **ALL GI RECORDS**
___All health care information
___Other

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS VIRUS), sexually transmitted diseases, psychiatric disorders/mental health, or drugs and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

_____ _____

Signature of Patient or Patient's Authorized Representative Date Signed

_____ _____

Relationship or status if signed by anyone other than patient (Parent, legal guardian, personal representative, etc.) Date Signed