Gastroenterology Care Center
859-263-0022
FAX 859-263-4666
160 N. Eagle creek dr. ste 202
Lexington, ky 40509

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: ____________________________________ Date of Birth:_____________

Address:

____

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Social Security Number: ____

I hereby authorize____ the disclosure of medical information to:

Dr. Laurie Haas **Dr. Kathleen Martin**

Please be sure to include the following information:

Discharge Summary Pathology X-ray reports Outpatient Notes

Operative Reports Labs ER Notes

Other ____

____
Patient Signature/Legal Representative Date

____
Signature of Witness Date