## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____(DOB)_____
(PATIENT'S NAME)

hereby authorize and request that:

*SoCal Gastroenterology*

**JOE M. CHEN, M.D., F.A.C.G.**
**THAI-VAN X. NGUYEN, M.D.**
**TIMNIT F. TEKESTE, M.D., M.P.H.**
**ALFRED T. REYNO, PA-C**

**10931 CHERRY STREET, SUITE 300**
**LOS ALAMITOS, CALIFORNIA 90720**
**(562) 493-1011 • FAX (562) 594-9226**

**release to:**

TO: _____

ADDRESS: _____

CITY: _____STATE:_____ZIP:_____

the following information:

____ History & Physical
____ Discharge Summary
____ Consultation Reports
____ Progress Notes
____ Operative Reports
____ ALL MEDICAL RECORDS
____ OTHER_____

____ Radiology Reports
____ Laboratory Reports
____ Pathology Reports
____ Emergency Room Records
____ GI Endoscopy Records (to include related pathology reports)

_____

Date(s) of treatment:_____

Purpose of release is for [ ] continuing medical care, [ ] billing, [ ] Other: _____

_____

**This authorization is in effect and shall remain in effect for 90 days unless otherwise specified by the patient. You have a right to receive a copy of this authorization.**

_____ _____
Date SIGNATURE OF PATIENT, Guardian or Conservator

_____ _____
WITNESS PRINT NAME OF PATIENT

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