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**AUTHORIZATION TO RELEASE MEDICAL INFORMATION
 "TO CGH"**

PATIENT INFORMATION

Name:
Address:
City, State, Zip:
Date of Birth:
Phone:

I authorize the following to release medical information from my record to:

FROM	TO
Name:	Name: Charlotte Gastroenterology & Hepatology
Address:	Address: P.O. Box 497 Att: Medical Records
City, State, Zip:	City, State, Zip: Huntersville, NC 28070
Phone:	Phone: 704-602-4321 (Medical Records)
Fax:	Fax: 704-375-6970 (Medical Records)

For the purpose of review/examination and further information, I authorize you to provide such copies as requested. The foregoing is subject to limitations below:

_____ Entire Record

_____ Specific Information (Indicated below)

I give special permission to release any information regarding: (initial on line below that you grant us permission to release the information to the above)

Substance Abuse ____ Psychiatric/Mental Health Info ____ HIV info ____

This authorization will automatically expire one (1) year from the date signed. I understand that I may revoke my consent at any time to the extent that action has been taken in reliance thereof.

Signed: _____ **Date:** _____

Witness: _____ **Date:** _____

 Unauthorized interception of this communication could be a violation of federal and state law(s). This document belongs to the sender and is legally privileged. The information contained in this communication is intended for use only by the authorized receiver named above. It cannot be re-disclosed for use by any other party. If you are not the authorized receiver you are hereby notified that any disclosure, copying or distribution is a privacy violation. Please notify the sender immediately by telephone to arrange for the return of the original document.