Charlotte Gastroenterology & Hepatology, P.L.L.C.
13808 Professional Center Dr.
Huntersville, NC 28078
Phone: (704) 377-4009
Fax: (704) 375-6970
www.charlottegastro.com

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: ____________

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