GASTROENTEROLOGY CLINIC OF SAN ANTONIO, P.A.

Charles W. Randall, M.D.
David L. Stump, M.D.
Jorge Munoz, M.D.
V. Franz Zurita, M.D.

Bassem W. Mazloum, M.D.
Gary Gossen M.D.
Russell Dean Havranek, M.D.
Nicholas P. Martinez, M.D.

AUTORIZATON FOR RELEASE OF HEALTH CARE INFORMATION

I hereby request and authorize _____

_____

To release copies of my records to: Gastroenterology Clinic of San Antonio, P. A.
8550 Datapoint Drive, Suite #200
San Antonio, Texas 78229
Office Number: (210) 615-8308 ** Fax (210) 615-8313

This authorization applies to all the reports checked:

___Admission Face Sheet
___History and Physical Exam
___EKG
___Discharge Summary
___Consultation Report
___Problem List
___Physicians Orders
___Progress Notes
___Medication Records
___Pathology Reports
___Laboratory Results
___X-Ray Report (type) _____
___Colonoscopy Reports
___Endoscopy Reports
___Other: _____
_____

Purpose of Disclosure: (check all the apply)

Medical Care _____ Insurance _____ Attorney _____ Other _____

TO THE PARTY RECEIVING INFORMATON: This information has been disclosed to you from the records whose confidentiality is protected by Federal Law. Federal Regulation (42CR, Part 2) prohibits you from making further disclosure without specific written consent of the person to whom it pertains. A general authorization for the release of medical information is not sufficient for this purpose.

I understand the records to be furnished or reviewed include information concerning my case history, examinations and treatment, including but not limited to and all information related to HIV testing, diagnosis, and treatment of testing for acquired immune deficiency syndrome (AIDS) or related disorders, if any. I understand this information may include reference to psychiatric treatment or testing and evaluation or treatment for substance abuse. The health care facility, employees and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein
(This Authorization is valid for 90 days.)

_____ Signature of Patient	_____ Printed Name of Patient	_____ Date
_____ Signature of Parent/Guardian	_____ Patients Date of Birth	_____ Date
_____ Signature of Witness	_____ Social Security Number of Patient	_____ Date