2093 Health Dr., Suite 201
Wyoming, MI 49519
(616) 452-7099
(616) 452-4142 Fax

Allan Coates, D.O.
David Tabor, D.O.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PATIENT NAME: ___________________________________ **DATE OF BIRTH**: _______________

ADDRESS: ____

I HEARBY AUTHORIZE THE RELEASE OF HEALTH INFORMATION

□ **TO MYSELF** □ **TO** (Name of Person or Organization): ____

FROM (Name of Person or Organization): ____

STREET ADDRESS: ________________________________

CITY / STATE / ZIP: ________________________________

PHONE: ___________________ FAX: _________________

PURPOSE OF DISCLOSURE

□ Personal □ Doctor's Care □ Legal □ Other

TYPE OF RECORDS TO BE RELEASED AND DATE(S)

□ Colonoscopy/ EGD Report(s) ____

□ Lab Report(s) ____

□ X-Ray Report (CT, US, Etc.) ____

□ Other (Specify) ____

I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME IN WRITING. THIS AUTHORIZATION SHALL REMAIN VALID FOR 1 YEAR OR UNTIL REVOKED BY ME, WHICHEVER OCCURS FIRST. AFTER IT IS REVOKED/EXPIRED, GASTROENTERLOGY ASSOCIATES OF WESTERN MICHIGAN, P.L.C WILL MAKE NO FURTHER DISCLOSURES TO THE ABOVED WITHOUT A NEW AUTHORIZATION. ONCE INFORMATION HAS BEEN DISCLOSED, IT MAY NO LONGER BE PROTECTED FROM FURTHER DISCLOSURES BY FEDERAL OR STATE PRIVACY LAWS.

I HAVE READ THE ABOVE INFORMATION AND ACKNOWLEDGE THAT I FULLY UNDERSTAND THE TERMS AND CONDITIONS OF THIS AUTHORIZATION.

PATIENT SIGNATURE: ____ **DATE**: _____________

WITNESS SIGNATURE: ____ **DATE**: _____________