AUTHORIZATION TO RELEASE RECORDS

PATIENT NAME_____ DOB _____

ADDRESS_____

PHONE_____ DATE_____

I HEREBY AUTHORIZE:

FLAGSTAFF SURGICAL ASSOCIATE GASTROENTEROLOGY

77 W. FOREST AVENUE, SUITE 107

FLAGSTAFF, AZ 86001

PHONE 928-773-2222 FAX 928-774-9625

TO RELEASE MY RECORDS CONCERNING MY TREATMENT AND/OR ILLNESS DURING MY DATES OF

FROM_____ TO_____

(DATE RANGE)

RELEASE TO:

_____

_____

_____

PHONE_____ FAX_____

SIGNATURE_____

(RELATIVE, STATE RELATIONSHIP)