PATIENT RECORD RELEASE FORM

Patient Information

Patient Name: _____

Date of Birth: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

I authorize Bhatti GI Consultants & Bhatti GI Surgery Center to release my records to the following:

Name of Provider: _____

Street Address: _____ Fax Number: _____

City: _____ State: _____ Zip: _____

Information to be Released

(We will release your entire record including but not limited: Office Notes, Procedure/Operative Reports, Lab Results, Imaging Results, Pathology Results)

_____ _____

Patient Name (PLEASE PRINT) Date

_____

Patient Signature