QUEEN CITY
GASTROENTEROLOGY
& HEPATOLOGY

320 Lillington Ave
Suite 101
Charlotte, NC 28204-3189

Phone: 704.362.4403
Fax: 704.362.4405

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize **QUEEN CITY GASTROENTEROLOGY & HEPATOLOGY, P.C.**

Address: **320 LILLINGTON AVE, SUITE 101**

CITY: **CHARLOTTE** STATE: **NC** ZIP CODE: **28204-3189**

To release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, conditions, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

I do hereby consent and authorize you to release copies of my medical record as identified above as appropriate, including current and previous medical records from other medical offices, practitioners, hospitals, and/or clinics which are a part of my medical record. **PLEASE NOTE:** this authorization includes consent for the release of alcohol, drug, psychiatric and psychological testing acquired immunodeficiency syndrome (AIDS), AIDS-related syndrome, and/or human immunodeficiency virus (HIV). It also includes any information concerning cancer, cancer testing and cancer results. I agree that a copy of this release or a facsimile document of this release shall be as valid as this original document. Please send all requested information as soon as possible to the address listed above.

Patient / Authorized Representative Signature: _____ Date: _____

THIS AUTHORIZATION EXPIRES NINETY (90) DAYS AFTER IT IS SIGNED.