Authorization to Schedule Testing/Discuss Test Results

Patient Name: _____ DOB: _____

I authorize Tucson Gastroenterology Specialists, PC to talk to the following people regarding scheduling of my testing or my test results if I am unavailable: **(please check all that apply)**

( ) No one other than myself

( ) My Spouse _____
Name of Spouse

( ) Other Family Member/Friend _____
Name of Family Member/Friend

( ) Okay to leave a detailed message on my answering machine at the following number;
Phone # (____) _____-_____

I understand that this statement will remain in effect until I notify the office in writing on a form provided by this office of any changes.

_____ _____
Patient Signature Date

Emergency Contact Information

Name: _____ Relationship: _____

Contact Phone Number(s): _____

Alternate/Seasonal Mailing Address

If your billing address is not the same all year long, please complete the area below so that you may continue to receive correspondence from our office. Thank you!

Address _____

_____
City State Zip Code

The above listed address is my alternate billing address for the following time period;
_____/____/_____ - _____/____/_____. (Please add a date range if possible)
From To

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name:_____ DOB:_____
Address:_____
Phone Number:_____

I hereby authorize Tucson Gastroenterology Specialists, PC to **release/obtain** (circle one) medical records.

To/From (Please include fax number if available, and address):_____
_____

Information to be released: _____ Complete written health record **or** _____ Information as listed below, include dates of service:
____Labs ____X-rays ____Colonoscopy ____EGD
____Office Consultations ____Other_____

I agree that information regarding the following may be released:
___Yes ___No Drug and/or Alcohol Abuse ___Yes ___No Communicable Diseases
___Yes ___No Psychiatric Disorders/Treatment ___Yes ___No Genetic Testing

The purpose of the release of information is:_____

I understand that if I am requesting a copy of my records for myself, the office may charge me $1.00 per page for copies up to 5 pages, then $.50 per page for any additional pages copied, with a maximum of $25.00. Medical records will be sent directly to other medical offices at no charge.

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken based upon the authorization. Unless otherwise revoked this authorization will expire 1 (one) year from the date signed.

We make every effort to process your request for medical records in a timely fashion, but please note that this process sometimes can take up to 2 weeks.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Printed name of Legal Representative Relationship to Patient

_____
Signature of Witness

Internal office use only:
Date received:_____ Date processed:_____
Amount charged:_____

Tucson Gastroenterology Specialists, PC
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