



Centers for
Gastroenterology

Specialists in Digestive Health

Providing Care Since 1980

Patient Release Form

Would you prefer that we contact you through **My Health Connection** secure messaging? **Y/N**

Please leave us a confidential phone number in which we can leave a detailed message: _____

Who are we authorized to speak with, **other than you or your doctor**? _____

Name

Relationship

Name

Relationship

By signing below I agree that:

- I understand that I am financially responsible to the Centers for Gastroenterology for any charges not covered by my insurance.
- I hereby assign all insurance payments for which I am entitled for medical or surgical services to the Centers for Gastroenterology.
- I authorize the Centers for Gastroenterology to release any medical information necessary to process my medical Insurance claims.
- I authorize the Centers for Gastroenterology to release all of my labs, procedures and test results to me.

Signature

Date

Print Name

Date of Birth