Inland Empire Gastroenterology Medical Group
Authorization for Medical Release of Medical Information

Authorization for use/or disclosure of Protected Health Information.

I, _____ hereby authorize: DOB: _____

Name of disclosing party: _____

Address: _____

City: _____ State: _____

Phone No: _____ Fax No: _____

To Disclose to:

Inland Empire Gastroenterology Medical Group
40404 California Oaks Rd, Suite C
Murrieta, CA 92562
P) 951-600-0288
F) 951-600-0188

Check the box and initial to specify which type of information is to be disclosed.

o Medical Information	_____	Start Date _____	End Date	_____
o Xray Results	_____	Start Date _____	End Date	_____
o Lab Results	_____	Start Date _____	End Date	_____
o Progress Notes	_____	Start Date _____	End Date	_____
o Consult Reports	_____	Start Date _____	End Date	_____
o Other	_____	Start Date _____	End Date	_____

Specify the records disclosed: _____

Duration: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here _____.

Revocattion: This authorization is also subject to written revocation by the member/patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have accted in reliance upon this authorization.

Redisclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Patient or Authorized Representative

Printed name: _____

Signature: _____

Date: _____

Witness

Printed Name: _____

Signature: _____

Date: _____