GASTROENTEROLOGY

8221 ROCHESTER AVENUE SUITE 130
RANCHO CUCAMONGA CA 91730
PHONE 909-360-1111 FAX 833-989-2428

Authorization To Release Healthcare Information

Patient Name: _____ Date of Birth: _____

I hereby request and authorize _____ to
(Facility Name)

disclose the following healthcare information:

☑ All health information (Excluding HIV, Mental Health, Alcohol/Substance Abuse and Genetic Testing)

Or

☐ My health information related to the following treatment(s) or condition(s)

_____
_____
_____
_____

of the patient named above to:

NEBI PC / Gastroenterology
8221 Rochester Ave Ste. 130
Rancho Cucamonga CA 91730
Fax : 833-989-2428

Patient Signature _____ Date _____

I may revoke this authorization at any time by providing my written revocation to the address at the top of this form. My revocation will not apply to any information already retained, used, or disclosed in response to this authorization. Unless sooner revoked, the automatic expiration of this authorization will be twelve (12) months from the date of signature.