AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION

-REQUEST FOR RECORDS-

Patient Name: _____ Date of Birth: _____

Patient Previous Name: _____ Phone Number: ( ) _____

I request and authorize the release of my health care information **FROM:**

Name of Medical Office: _____

Address: _____

City, State: _____ Zip: _____

Phone: _____ Fax: _____

Information to be released:

☐ Last Colonoscopy/Endoscopy as well as associated Pathology Results

☐ Last Office Visit Note ☐ Labs and/or imaging results ☐ Other _____

_____

Please send requested records **TO:** Northwest Gastroenterology & Endoscopy
via **FAX: 360-734-8748**

Records may also be mailed to our office at:
2979 Squalicum Parkway, Suite 301 Bellingham, WA 98225

For additional questions please contact Medical Records at 360-734-1420

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Name of Patient or Personal Representative Date

_____
Description of Personal Representative's Authority