Authorization for Release of Medical Records

I, ____ ,

do hereby consent and authorize ____

to release to **Yadkin Valley Gastroenterology** my medical records relating to my identity, diagnosis, prognosis, and treatment, including but not limited to treatment of drug and alcohol related illness, psychiatric treatment, diagnosis and/or treatment of HIV related illness, sickle cell disease, or hepatitis. I understand that extent or nature of the medical information to be disclosed includes:

____

I also understand that the purpose of this disclosure it to: ______________________________________

____

Furthermore, I understand that this authorization is revocable by me at any time when I provide a written, signed notice of the revocation to **Yadkin Valley Gastroenterology**, except to the extent that any action has been taken on this release. Otherwise this consent will remain in force for 90 days.

Special limitation or restrictions (if any): ______________________________________

Signature of Patient	Date	Signature of Witness	Date
Signature of parent/legal guardian or authorized representative		Patient Date of Birth	

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