COLON, STOMACH & LIVER CENTER, LLC
Satinder Gill, MD | Hiwot Desta, MD
Colleen Nappi, CFNP / Jessica Gandhi, PA
19455 Deerfield Ave., Suite 201 | Lansdowne, VA 20176
(P) 703.723.3670 | (F) 703.723.8336
www.loudouncslcenter.com

Authorization of Medical Release of Medical Information

Attention:

Patient's Name: Date of Birth:

I, ________________________, request and authorize ___________________________ to release the healthcare information of the patient listed above to:

Provider/Facility Name:

Address:

Contact Number: Fax Number:

This request and authorization applies to:

- ☐ Healthcare information related to the following treatment, condition or dates: ____
- ☐ All Healthcare Information
- ☐ Other: ________________________

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for twelve (12) months from the date of the signature. I understand that I may cancel with written notification, but that it will not affect any information released prior to notification of the cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition their treatment of me on whether or not I sign this authorization.

Signature: _______________________________________ Date: __________