Long Beach Gastroenterology Associates
A MEDICAL GROUP, INC.

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DIPLOMATES AMERICAN BOARD OF INTERNAL MEDICINE
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MEDICAL RECORDS REQUEST

LAST NAME FIRST NAME MIDDLE INITIAL DATE OF BIRTH

STREET ADDRESS CITY STATE ZIP

I authorize

_____
HOSPITAL OR PHYSICIAN

_____
COMPLETE ADDRESS

to provide summary or copy of my medical records to:

LONG BEACH GASTROENTEROLOGY ASSOCIATES
2880 ATLANTIC AVENUE, SUITE 100 – LONG BEACH, CA 90806
(562) 595-5421 - Fax (562) 426-2862

for the purposes of medical evaluation and treatment, as specified below:

MEDICAL INFORMATION

(1) ___ will have not restrictions

(2) ___ will be restricted to: _____

_____

Authorization shall be effective immediately and valid until _____
(give date)

I have received a copy of this authorization. YES ( ) NO ( )

Release or transfer of the specified information to any person or entity not specified herein is prohibited. An additional written consent must be obtained for a proposed new use of the information or for its transfer to another person or entity.

PATIENT'S SIGNATURE: _____ DATE: _____
or

_____ (personal representative)