

# Long Beach Gastroenterology Associates

A MEDICAL GROUP, INC.

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DIPLOMATES AMERICAN BOARD OF INTERNAL MEDICINE  
DIPLOMATES SUBSPECIALTY BOARD OF GASTROENTEROLOGY

## MEDICAL RECORDS REQUEST

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LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH
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STREET ADDRESS	CITY	STATE	ZIP
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***I authorize***

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HOSPITAL OR PHYSICIAN

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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)