

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)