Authorization for Medical Records Release

Patients Name:_____ D.O.B._____

Other Names Used:_____ Patient's SS#_____

From:_____

Please send Information to:

Dr. Liz Cruz Partners in Digestive Health
4110 N. 108th Avenue, Ste. 105
Phoenix, AZ 85037
Phone: 623-772-6999
Fax: 623-772-6444

You may disclose the following health care information: (Circle all that apply)

My Endoscopies, Colonoscopies and Pathology Reports

Imaging and Labs

All My Health Information

I am requesting this information to provide continuation of healthcare. I understand that I have a right to receive a copy of my medical records.

_____ _____
Patient/Authorized Individual Signature **Date**

_____
Print Name