Nashville Gastro Consulting, PLLC
William F. Alexander, M.D.

343 22nd Avenue North, Nashville, TN 37203
Ph. 615.327.7835 Fax 615.321.4146
Setting the standards for exceptional digestive care

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: _____

Date of Birth: _____

Social Security#: _____

I request and authorize **NASHVILLE GASTRO CONSULTING, PLLC** to release my medical records to:

_____

_____

_____

This request and authorization applies to:

_____ Health Care Information relating to the following
(Patient Name)

treatment, condition or dates of Treatment:_____
(if applicable)

_____ All health care information

_____ Other

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS VIRUS), sexually transmitted diseases, psychiatric disorders/mental health, or drugs and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

_____ _____
Signature of Patient Date
(or Patient's Authorized Representative)

_____ _____
Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative, etc.) Date

NGC TO RELEASE RECORDS