Advanced Care Gastroenterology Associates

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Authorization for Release of Medical Records

I hereby authorize ____ to disclose the

*****Insert Primary Care Physician and/or doctor's office information here*****

following health record information for the purposes of continuation of

medical care to Dr. Sobia Ali:

Patient Name: ________________________________

Date of Birth: _________________________ Phone #: ____________________________

{ } History & Physical Exam

{ } Discharge Summary

{ } ER Physician Notes / Labs

{ } Endoscopy (EGD) / Colonoscopy

{ } Pathology Reports

{ } Other: ______________________________

{ } Last Progress Note

{ } Laboratory Reports

{ } Operative Reports

{ } Insurance Verification

{ } X-Ray / MRI / CT Scans

____

Patient Signature: ______________________________ Date: ______________________

Sobia Ali, MD

Advanced Care Gastroenterology Associates