Gateway Medical

Authorization for Release of Medical Information

Patient Name *(Print)* _____ Patient Date of Birth _____ Patient ID# _____

RELEASE FROM PREVIOUS PROVIDERS

❑ I hereby authorize the release of my health information relative to my care and treatment within the previous two years. My consent to release this health information from my medical records shall continue until I expressly revoke this consent. I authorize Gateway Medical LLC to release or obtain my health information:

_____

(List Specific Information Being Requested)

"to" or "from:"

_____

(Name of Person or Name of Other Company)

for the following purpose:

_____

(Intended Use of Information)

VERBAL COMMUNICATION RELEASE

❑ I grant permission to Gateway Medical to verbally disclose my protected health information to the individual(s) named below:

Name of Individual	Relationship	Phone Number

Patient Signature: _____ Date: _____

Personal Representative*: _____ Date: _____

Legal Authority to Act for Patient*: _____ Date: _____