Gastroenterology Specialists
of North Houston

T. Gordy Alam, MD
17521 St. Luke's Way Suite 190
The Woodlands, TX 77384
Phone: 936-321-0000
Fax: 844-202-3967

AUTHORIZATION TO RELEASE INFORMATION TO DR. T. GORDY ALAM

I the undersigned hereby authorize: (Doctors Name, Phone, and Fax Number)

____

____

____

To release this information specified below to the physician marked above.
The reason for this release of information is ( ) continuity of care or ( ) other______________.

I understand that my records are confidential and cannot be disclosed without written authorization, except as otherwise provided by law.

This authorization is valid for 6 months and may be revoked by the patient, orally or in writing at any time prior to 6 months.

Information to be released should include all history, physical exam, consultation and progress notes, colonoscopy, EGD, ERCP, capsule endoscopy, pathology, radiology reports, and all correspondence relating to my medical care unless otherwise specified below. Your prompt attention is greatly appreciated.

____
Patient Signature

____
Patient Name (Printed)

____
Date of Birth

____
Date

According to State/Federal Law, the following must be signed in order to process all records request, if such information exists in your chart.

______________________________ Mental Health Records
______________________________ Alcohol/Substance Abuse Records
______________________________ HIV Records