



Gastroenterology Specialists
of North Houston

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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