Gastroenterology Consultants Southwest, L.L.P.

Authorization Form
Release of Protected Health Information

Patient Name ______________________________ Date of Birth: ______________

TO: __________________________________ SS# ____________________

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By signing this form I authorize you to release my protected health information to:

Robert E. Davis, M.D.
1111 Highway 6, Suite 105
Sugar Land, Texas 77478
Phone Number: (281) 491-9779
Fax Number: (281) 491-3551

The health information you may release subject to this authorization is as follows:

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The reasons or purposes for this release of information are as follows:

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This authorization shall be in force and effective on this date:

____________________________________ ________________________
Signature of Patient or Personal Representative Date