

Gastroenterology Consultants Southwest, L.L.P.

**Authorization Form
Release of Protected Health Information**

Patient Name _____ Date of Birth: _____

TO: _____ SS# _____

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

Keith Fiman, 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:

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

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

Signature of Patient or Personal Representative

Date