

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:

Frank L. Lanza, M.D.
7777 Southwest Freeway, Suite 762
Houston, Texas 77074
Phone Number: (713) 977-9095
Fax Number: (713) 779-5676

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