

GASTROENTEROLOGY CONSULTANTS SOUTHWEST LLP

**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 H. Fiman M.D.
1111 Highway 6 #105
Sugar Land, Texas 77478
Ph.: 281-491-9779
Fax: 281-491-3551

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