Nashville Gastro Consulting, PLLC
William F. Alexander, M.D.

343 22nd Avenue North, Nashville, TN 37203
Ph. 615.327.7835 Fax 615.321.4146

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: _____

Date of Birth: _____

Social Security#: _____

I request and authorize _____to release my medical records to:

Dr. William F. Alexander -- Nashville Gastro Consulting, PLLC
343 22nd Ave., N.
Nashville, TN 37203
FAX – 615-321-4146

This request and authorization applies to:

_____ Health Care Information relating to the following
(Patient Name)
treatment, condition or dates of Treatment:_____
(if applicable)
_____ All health care information

_____ Other

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS VIRUS), sexually transmitted diseases, psychiatric disorders/mental health, or drugs and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

_____ _____
Signature of Patient (or Patient's Authorized Representative) Date

_____ _____
Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative, etc.) Date

NGC TO RECEIVE RECORDS