AUTHORIZATION TO RELEASE MEDICAL INFORMATION

TO: ____

____

____

Phone: _____________________________________

Fax: _______________________________________

By signing this form, I ____________________ authorize your office to furnish all relevant medical information regarding injuries or illnesses, for which you have examined, observed or treated me to the practice/physician listed below.

The records that I request be disclosed are described as follows (please list the name of the provider, department, date(s) of service, type of record and any other identifying information):

____
____
____

Dr. ___________________________
The GW Medical Faculty Associates
Department of Surgery/Colon & Rectal
2150 Pennsylvania Ave., NW
Suite _____________
Washington, DC 20037
Phone: (202) 741-______
Fax: (202) 677- _______

_________________________	_________________________
Individual (Signature)	Individual/Guardian/Legal Representative
_________________________	_________________________
Print Name	Print Name
_________________________	_________________________
Date	Relationship/Authority
_________________________	_________________________
Social Security Number (Individual)	Date of Birth (Individual)