

Angela N. Hutzenbuhler, M.D.

Gastroenterology

Authorization for Release of Information

Name of Patient \_\_\_\_\_ date of birth \_\_\_\_\_

Angela N. Hutzenbuhler, M.D., Gastroenterology is authorized to release protected information about the above named patient to the entities named below:

**Please check each entry/person who you approve to receive information.**

<input type="checkbox"/> Voice Mail	<input type="checkbox"/> Test Results <input type="checkbox"/> Financial <input type="checkbox"/> Appointments <input type="checkbox"/> Anything
<input type="checkbox"/> Employer <input type="checkbox"/> School	<input type="checkbox"/> Test Results <input type="checkbox"/> Financial <input type="checkbox"/> Appointments <input type="checkbox"/> Anything
<input type="checkbox"/> Spouse / partner	<input type="checkbox"/> Test Results <input type="checkbox"/> Financial <input type="checkbox"/> Appointments <input type="checkbox"/> Anything
<input type="checkbox"/> Parent (s) – list name(s) _____ _____	<input type="checkbox"/> Test Results <input type="checkbox"/> Financial <input type="checkbox"/> Appointments <input type="checkbox"/> Anything
<input type="checkbox"/> Other – name(s) _____ _____	<input type="checkbox"/> Test Results <input type="checkbox"/> Financial <input type="checkbox"/> Appointments <input type="checkbox"/> Anything

\_\_\_\_\_  
patient signature

\_\_\_\_\_  
date