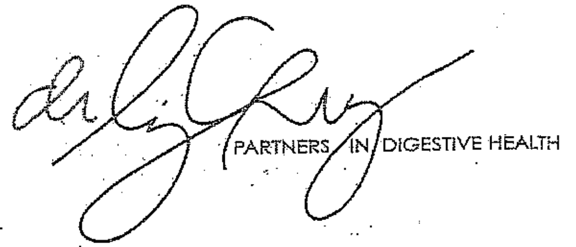

Authorization for Medical Records Release

Patients Name: ______________________________ D.O.B.______________

Other Names Used: ______________________________ Patient's SS#__________

Requesting Information from:
Dr. Liz Cruz Partners in Digestive Health
4110 N. 108th Avenue, Ste. 105 Phoenix, AZ 85037
Phone: 623-772-6999 Fax: 623-772-6444

Send to: ____

Address: ____

Fax: __________________________ **Phone:** __________________________

You may disclose the following health care information: (Circle all that apply)

My Endoscopies, Colonoscopies and Pathology Reports

Imaging and Labs

All My Health Information

I am requesting this information to provide continuation of healthcare. I understand that I have a right to receive a copy of my medical records.

______________________________ ______________
Patient/Authorized Individual Signature **Date**

____
Print Name