

# Central Indiana Gastroenterology Group

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## AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND INFORMATION

CIRCLE CHOICE:                      RELEASE RECORDS TO:                      RELEASE RECORDS FROM:  
DR./ HOSPITAL: \_\_\_\_\_  
PHONE: \_\_\_\_\_ ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
PATIENT NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
DOB: \_\_\_\_\_ SSN: \_\_\_\_\_  
INFORMATION TO BE RELEASED: \_\_\_\_\_

PURPOSE OF RELEASE: \_\_\_\_\_

CIRCLE CHOICE:                      RELEASE RECORDS TO:                      RELEASE RECORDS FROM:  
JON MAIER, M.D.    CHRISTOPHER FOSTER, M.D.    ROD NISI, M.D.    THOMAS NOWAK, M.D.

*I, THE UNDERSIGNED, HEREBY AUTHORIZE THE ABOVE LISTED FACILITY TO RELEASE THE ABOVE NAMED INFORMATION FROM MY MEDICAL RECORDS CONCERNING MY HOSPITALIZATION OR TREATMENT, INCLUDING BUT NOT LIMITED TO, INFORMATION REGARDING TREATMENT OR DRUG OR ALCOHOL ABUSE, PSYCHOLOGICAL CONDITIONS, HIV TESTING OR AN AIDS RELATED CONDITION OR ANY OTHER MEDICAL CONDITION. REVIEW OF THE RECORDS IS ALSO AUTHORIZED.*

*I UNDERSTAND THAT I MAY REVOKE THIS REQUEST AT ANY TIME IN WRITING, BUT THE REQUEST SHALL REMAIN VALID UNTIL REVOKED OR UPON EXPIRATION OF SIXTY (60) DAYS, WHICH EVER OCCURS FIRST.*

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
GUARDIAN OR POWER OF ATTORNEY

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS