Gastroenterology Specialists of Delaware, LLC

Diplomate of the Board of Gastroenterology *Diplomate of the Board of Internal Medicine*

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George Benes, MD Michael J Brooks, MD

Consent for Release of Health Information

Date: _____

Patient Name: _____ DOB: _____ SS#: _____

Current Address: _____

_____

Phone: _____

Please note: Medical Records Requests may be subject to a copy fee as allowed by Delaware Board of Medical Licensure and Discipline Section 16.0. A copy of fee schedule is available upon request

I authorize Gastroenterology Specialists of DE LLC to release my health information records to the following:

To: _____

Address: _____

_____

Phone: _____ Fax: _____

Reason for Request: _____

Patient Signature: _____

For office use only: Fee: _____ Date paid: _____ Processed by: _____Mailed: ☐ Faxed: ☐ Pickup: ☐