

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

TO: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PATIENT: \_\_\_\_\_ DOB: \_\_\_\_\_

I HEREBY AUTHORIZE:

**DR. JOEL SPELLUN; DR JAY SORGMAN; DR. PHILIP MCANDREW; DR. BRET ANCOWITZ**

**TO: RELEASE or OBTAIN:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

FOR THE PURPOSE OF CONTINUING CARE.

ANY INFORMATION GIVEN OR RECEIVED SHALL NOT BE FURTHER RELAYED TO ANY OTHER SOURCE  
WITHOUT MY WRITTEN CONSENT.

THIS AUTHORIZATION MAY BE WITHDRAWN AT ANY TIME

SIGNATURE OF PATIENT: \_\_\_\_\_

DATE: \_\_\_\_\_

CONSULTANTS IN GASTROENTEROLOGY, INC  
148 WEST RIVER STREET  
PROVIDENCE, RI 02904  
401-421-6306 (phone)  
401-453-0330 (fax)