ADVANCED GASTROENTEROLOGY ASSOCIATES *A Division of Allied Digestive Health*

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Dear Dr. _____:

I authorize the release of my medical records to Advanced Gastroenterology Associates.

Please release only the following medical records (where applicable):

- o Upper endoscopy report(s) and pathology results
- o Colonoscopy report(s) and pathology results
- o Office visit note(s)
- o Radiology
- o Other _____

Thank you.

_____ _____

Printed Name Date of Birth

_____ _____

Signature Date

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