☐ **STAT** (If indicated)

SEVG

SOUTHEAST VALLEY GASTRO

875 S. DOBSON RD. CHANDLER, AZ 85224 (480) 899-9800 FAX (480) 899-2994

2730 S. VAL VISTA DRIVE STE. 158 BLDG. 10 GILBERT, AZ 85296 (480) 782-5005

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TINA M. DVOREN-BAKER, N.P. CHRISTINA F. MORGAN, P.A.-C MOLLY WYANT, PA-C

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____, allow Southeast Valley Gastroenterology Consultants to release or receive any necessary medical records.

_____ Date: _____

Patient's Signature

Date of Birth: _____ SEVG Physician: _____

****

FOR OFFICE USE ONLY:

☐ I authorize Southeast Valley Gastroenterology **to release information to:**

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip

_____
Phone #/Fax# (Include Area Code)

OR

☐ I authorize Southeast Valley Gastroenterology **to obtain information from:**

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip

_____
Phone #/Fax# (Include Area Code)

FOR THE PURPOSE OF: (Check all that apply)

☐ Continuing Care ☐ Referral to Specialist ☐ Worker's Comp ☐ Insurance
☐ Legal Investigation ☐ Change of Doctor ☐ Other (specify):_____

INFORMATION TO BE RELEASED (*Please check ALL that apply and specify dates*):

☐ Clinic Visit Notes _____ ☐ Discharge Summary _____
☐ Lab Reports _____ ☐ X-ray/Scans _____
☐ Operative Reports _____ ☐ Hospital Visit Record_____
☐ Pathology Reports _____ ☐ ER Visit Record _____
☐ Other (Please specify) _____

_____

Date	Initial Request	2nd Request	3rd Request
Requested for:	**CS**	**AB**	**MA** **SP** **YP**

SEVG

SOUTHEAST VALLEY GASTRO

Thank you for selecting Southeast Valley Gastroenterology Consultants P.C. for your medical care.

Please be advised:

If your insurance requires you to have a referral or authorization for your office visit or procedure, it is ultimately **your responsibility** to obtain these before your appointment.

Our office will put forth as much effort as possible to help obtain these documents, but the **patient is ultimately responsible for any resulting costs** that may be associated with your visit or procedure.

Please call your insurance carrier so that you can better **understand your benefits**. Although our office does verify coverage, online services only provide limited information.

It is your responsibility to know which insurance is your primary carrier and which is your secondary. We rely on the information that the patient provides.

Our office **does not participate with AHCCCS insurance**. We will not accept any AHCCCS patients.

Many HMO's such as Aetna and Humana require authorization numbers for office visits and procedures. If we do not have the authorization at the time of this visit, your visit will be rescheduled.

THE PATIENT IS HELD ACCOUNTABLE FOR UNDERSTANDING THEIR BENEFITS, PROVIDING REFERRALS, OBTAINING AUTHORIZATIONS AND PAYING SUBSEQUENT OUT OF POCKET EXPENSES.

Thank you,

Southeast Valley Gastroenterology Consultants P.C.

Patients Signature: _____ Date: _____