

**G2Endo**

**Endocrinology & Metabolism**

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www.G2Endo.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

|  |  |  |  |
| --- | --- | --- | --- |
| Patient’s Name: |       | Date of Birth: |       |
| Previous Name: |       | Social Security #: |       |
| I request and authorize |       | to |
| release healthcare information of the patient named above to:G2EndoEndocrinology & MetabolismMalini Gupta-Ganguli, M.D., CCD/ Thomas A. Hughes, M.D. |
| This request and authorization applies to: |
| [ ]  Healthcare information relating to the following treatment, condition, or dates: |  |
|  |       |
| [ ]  All healthcare information |
| [ ]  Other: |       |
|  |
| [ ]  Yes [ ]  No I authorize the release of any photograph taken of me during and for treatment purposes. |
| [ ]  Yes [ ]  No | I authorize the release of any records regarding drug, alcohol, or mental health treatment to the office of Dr. Malini Gupta-Ganguli. |
| Patient Signature: |  | Date Signed: |  |
|  |
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