AUTHORIZATION TO RELEASE INFORMATION

I, _____, hereby authorize Coastal Gastroenterology, PC to release information regarding my health or finance history to the following (only in case of emergency or my request):

Name	Phone	Relationship

_____ I also authorize messages to be left on my answering machine or voicemail.

_____ I authorize email communication (unencrypted) from Coastal Gastroenterology, PC.

Patient's Signature _____ Date _____

PREFERRED PHARMACY INFORMATION

Name of Pharmacy: _____

Street: _____

City: _____ State: _____

Phone: _____

_____ Yes, I authorize Coastal Gastroenterology, PC to obtain my medication history during my office vist from my pharmacy and insurance companies

PATIENT'S INSURANCE PREFERRED LAB

Many insurance companies are now specifying which commercial laboratories, hospital, and free standing clinics they are in network with. Labs that are ordered by the physician must be done at a reference lab. **ALL Laboratory orders will be sent to Lab Corp** unless you indicate otherwise. Please note, you will receive a separate bill from the outside lab.

Please indicate below your insurance carrier's preferred lab. Inaccurate or erroneous information will result in your being held responsible for all lab charges.

★ Please specify below if you prefer a different lab company ★

_____ Other (Please Specify) _____

If no laboratory is provided, all orders will be sent to Lab Corp

By signing this document, I hereby acknowledge that I understand and agree to the above content

Patient Signature _____ **Date:** _____