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**Authorization to Release Patient Information**

I, \_\_\_\_\_, hereby authorize the physicians and staff of this practice to release any and all information pertaining to my health care, test results, procedures, billing and/or accounting information to the following person(s) or agencies:

\_\_\_ Spouse    \_\_\_ Parents    \_\_\_ Other – Siblings, Friends, Relatives

Please specify other \_\_\_\_\_

I further authorize the physicians and their staff to dispense results of my medical exams in one or more of the following ways:

**May leave a message during business hours to return call to physicians' office:**

\_\_\_ Home    \_\_\_ Work    \_\_\_ Ans. Machine at home    \_\_\_ Voice Mail at Work

\_\_\_ Cell Phone – number ( ) \_\_\_\_\_

**May leave type of test performed and test results:**

\_\_\_ Answering machine at home    \_\_\_ Voice Mail at Work    \_\_\_ Cell Phone

I understand that this office will release any information to those persons whom I have determined may receive this information without separate consent. In addition, I understand that this relates to all medical as well as billing information.

This will be actively enforced. If you wish to change the status of this form, you must do so, in person, in writing, in the office. A copy of the privacy notice will be given to you upon request.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness