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Plaza 1  
1417 South Cliff Avenue, Suite 300  
Sioux Falls, SD 57105  
(605) 322-8630  
Fax (605) 322-8631

DATE: \_\_\_\_\_

PATIENT: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

I give permission to Avera Medical Group Gastroenterology to release information concerning my health care (including lab and other results, appointment information, etc.) to my spouse, other family member, or other person(s) as listed below.

*Please Print*

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Telephone: # \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Telephone: # \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Telephone: # \_\_\_\_\_

Can we leave results (detailed medical information) on your answering machine?  Yes  No

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