LAKESIDE ENDOSCOPY CENTER, LLC MEDICAL RECORDS DISCLOSURE AUTHORIZATION

	hereby authorize Lakeside I	Endoscopy Center, LLC
(Specifically describe the info	g protected health information: rmation to be disclosed, including mean provided, level of detail to be released, o	
	tion may be disclosed to: (Name of per address, or fax number information to	
1	tion is being disclosed for the following choose to provide an explanation indi	
This authorization shall be in f □ Date:	orce until:	
I understand that, as set forth i writing at any time by sending	n the Center's Privacy Notice, I may ra written notice to:	revoke my authorization in
Lakeside Endoscopy Center, LI 17001 Lakeside Hills Plaza, Su Omaha, NE 68130 Attn: Privacy Officer		
disclosure of the protected heal I understand that information	is not effective to the extent that the th information. disclosed pursuant to this authorization may no longer be protected by federal of	on may be subject to re
Name of Patient	Patient Date of Birth	Date
Signature of Patient or Personal	Representative Personal Representative	ntative's Authority
Name of Witness	Signature of Witness	 Date