GCNS
GASTROENTEROLOGY
CONSULTANTS OF THE NORTH SHORE

YOLANDRA L. JOHNSON, M.D.
JAMES L. ROSENBERG, M.D.
JONATHAN F. WILLIAMS, D.O.

PERMISSION FOR RELEASE OF RECORDS

I, _____ hereby authorize

_____ to

(GI doctor, Primary care doctor or hospital)

release records to Yolandra L. Johnson, M.D. of GCNS, S.C. at the address below. This is to include the diagnosis and records of any treatment or examination rendered to me.

Gastroenterology Consultants of the North Shore
Yolandra L. Johnson, M.D.
506 Green Bay Rd.
Kenilworth, IL 60043-1598
Phone: (847)256-8661 Fax: (847)256-1598

Please include all information, including, but not limited to: diagnosis, records of treatment or examination, results of blood and stool tests, X-Rays, Colonoscopy, Endoscopy, Sigmoidoscopy and pathology reports.

Signature: _____ Date: _____

Date of Birth: _____

Address: _____

_____