Gastroenterology Specialists

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Name: _____ Date of Birth: _____
Social Security #: _____

SELECT ONE:

_____ Please **SEND** my medical records **TO** _____ by faxing it to # _____ or by mailing it to _____.

_____ Please **GET** my medical records **FROM** _____. Their fax # is _____ and their address is _____.

Records to be released:

- ☐ All records
- ☐ Lab Results
- ☐ X-ray Report
- ☐ Procedure Reports
- ☐ Pathology
- ☐ Progress Notes /Office visits notes
- ☐ Emergency Room Records
- ☐ Other: _____

Purpose of Disclosure:

- ☐ Continuing care with my _____ (physician specialty).
- ☐ Personal Copy.
- ☐ Transferring care to another physician.
- ☐ Other (please specify): _____

I Understand that:

1. Information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.
2. This authorization will remain in effect for twelve months from the date signed.
3. I may revoke this authorization at any time in writing, but if I do, it will not affect any actions taken prior to receiving the revocation.
4. I may refuse to sign this authorization and that it is strictly voluntary.
5. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
6. If I do not sign this form, my health care and the payment for my health care will not be affected.
7. That I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.

_____ _____
Patient/Guardian/Representative Signature Date

_____ _____
Patient/Guardian/Representative Printed Name Date

_____ _____
Witness Signature Date

FOR OFFICE USE ONLY: Records were Faxed / Mailed / Given to patient on _____ Initials: _____

RECORDS REQUESTED BY: Provider / Patient

MRR-004