GASTRO HEALTH

FORMERLY ASSOCIATES IN GASTROENTEROLOGY

MEDICAL RECORDS REQUEST FORM

Release of Medical Records To:

_____
_____
_____
_____

I hereby authorize Gastro Health (Formerly Associates in Gastroenterology), to release my medical records to the above indicated party.

Patient's Name: _____ D.O.B.:_____

Patient's Signature: _____ Date: _____

I understand by my signature above I agree that there are no limitations placed on dates, history or illness, diagnostic and therapeutic information including treatment for sexually transmitted disease, drug abuse and psychiatric care. I also understand that this consent will automatically expire 6 months from the date signed. Furthermore, this consent will be revoked upon completion of the request and will not serve for any further request. I reserve the right to withdraw this authorization at any time.

Employee Signature: _____ Date Faxed: _____

Printed Employee Name: _____ Requesting Provider: _____

CONFIDENTIALITY NOTICE:

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