



## AUTHORIZATION TO RELEASE/OBTAIN MEDICAL RECORDS

TODAY'S DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ Digestive CARE Provider: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

### Records Released *From*:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### Records Released *To*:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### Information to be Release/Obtained:

- Complete Medical Record     Lab Reports     Billing Records     Clinical Records Related To:

\_\_\_\_\_  
\_\_\_\_\_

- I understand that the information in my health record may include information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
- I understand I have the right to revoke this authorization, in writing, at any time. The revocation will not apply to information that has already been released as a result of this authorization.
- I understand that the PHI used, disclosed, or released pursuant to this authorization may be subject to redisclosure by the recipient of my PHI and will no longer be protected by state or federal privacy regulations.
- I understand that Digestive CARE may charge a fee for copying and sending my records.
- I understand that requests may take up to 72 hours.
- I authorize *Gastrocare, LLP dba Digestive CARE* to release or obtain medical records as specified above.

**SIGNATURE** (Patient or Authorized Representative) \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

**PRINTED NAME** (Patient or Authorized Representative) \_\_\_\_\_