Phone: (336) 448-2427 • www.gapgi.com • Fax: (336) 765-2869
Providing compassionate, patient-centered gastroenterology care to the greater Triad area

Authorization for Release of Medical Information

PATIENT INFORMATION:

Name: _____ Epic MRN: _____ *(office use only)*

Date of Birth: ____ /_____ /_____ SS # (last 4 digits): ___ ___ ___ ___ Phone: (_____) _____ - _____

Street Address/City/State/Zip: _____

OBTAIN RECORDS FROM:

Practice Name: _____ Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

Street Address/City/State/Zip: _____

RELEASE RECORDS TO:

Practice Name: _____ Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

Street Address/City/State/Zip: _____

RECORDS TO BE RELEASED:

Date(s) or date range of service: _____

Type: □ All records □ Office notes only □ Procedures/Pathology only □ Labs only □ Imaging reports only

□ Other: _____

Reason: □ Continuation of care with another provider □ New gastroenterologist □ Personal use

□ Other: _____

Indicate if you DO NOT want records related to the following released:

□ DO NOT share records regarding the treatment of drug and/or alcohol abuse

□ DO NOT share records regarding the treatment of mental health or psychiatric disorders

AUTHORIZATION:

1) This authorization can be revoked at any time according the GAP privacy practices. This request must be made in writing and sent to the same place as the original request. Attach a copy of this release if possible. Treatment, payment, enrollment in any health plan is not conditioned on signing this authorization.
2) Once records are released, the information is not protected by GAP and may potentially be re-disclosed by the party who received them. GAP, its employees, officers, and attending physicians are released from legal responsibility or liability for release of the above information to the extent indicated and authorized.
3) I have read and understand this information. I, the patient or a person authorized to act on behalf of the patient to sign this document, have received a copy of this form verifying authorization for the use or disclosure of the protected health information under the above stated terms.

I authorize the release of medical information as indicated above. This authorization expires in 90 days.

_____ _____

Signature of patient (or legal representative and relationship to patient) *Date of request*

_____ _____

Signature of witness *Date*