



# AUTHORIZATION TO RELEASE MEDICAL RECORDS

## PATIENT INFORMATION

Patient's name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

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

City/State/Zip Code: \_\_\_\_\_

Date of Request: \_\_\_/\_\_\_/\_\_\_

OR

I authorize GastroCare Physicians of Georgia  
to **release** information to:

\_\_\_\_\_  
Name of Provider or Facility

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

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

I authorize GastroCare Physicians of Georgia  
to **obtain** information from:

\_\_\_\_\_  
Name of Provider or Facility

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

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

### CONSENT FOR RELEASE OF MEDICAL INFORMATION INCLUDING, IF ANY, HIV, AIDS, PSYCHIATRIC, AND SUBSTANCE ABUSE

**I hereby authorize the above physician/hospital/facility to release information including, if any, psychiatric or psychological information, infections or contagious disease information (including HIV/AIDS) and/or information about drug or alcohol abuse or treatment of the same from the health record.**

**I understand** that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

**I understand** that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

**I understand** that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

**To release my:**

**Last two office notes, recent Lab reports, Radiology Studies, and any pertinent records sent to you by other physicians for continuity of care.**

**Other as follows** \_\_\_\_\_  
\_\_\_\_\_

Patient Name: \_\_\_\_\_ Witness: \_\_\_\_\_

Patient/Legal Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_ Date at which this request will expire: \_\_\_/\_\_\_/\_\_\_