



AUTHORIZATION TO RELEASE MEDICAL RECORDS

Phone 404-282-5600

Fax 404-282 5599

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: ____/____/____