Phone: (336) 448-2427 • www.gapgi.com • Fax: (336) 765-2869
Providing the latest in contemporary outpatient gastroenterology care to the greater Triad area

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT INFORMATION:

Name: _____ Date of Birth: _____ MRN: _____
(for office use only)

Address: _____ Last 4 digits of SS#: _____

City/State/Zip: _____ Phone: _____

OBTAIN RECORDS FROM:

Practice Name: _____

Address: _____

Phone: _____ Fax: _____

RELEASE RECORDS TO:

Name: _____

Address: _____

Phone: _____ Fax: _____

RECORDS TO BE RELEASED:

☐ *Office notes* ☐ *Labs* ☐ *Imaging report(s)* ☐ *Procedures/Pathology* ☐ *All records* ☐ *Other:* _____

Date(s) of information to be disclosed: *from* _____ *to* _____

Purpose of the release: ☐*Continuation of care* ☐*New gastroenterologist* ☐*For another doctor* ☐*Personal use* ☐*Other*

Indicate whether you authorize the release of information regarding each of the choices below:

The diagnosis or treatment of AIDS, including results of HIV tests	☐*N/A*	☐*Yes*	☐*No*
The diagnosis or treatment of drug and/or alcohol abuse	☐*N/A*	☐*Yes*	☐*No*
The treatment and/or consultation for mental health or psychiatric disorders	☐*N/A*	☐*Yes*	☐*No*

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 unless otherwise indicated.

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

_____ _____
Signature of witness *Date*

Revised 8/21/2019