



Gastro One

Excellence in Digestive Health

G.I. Diagnostic and Therapeutic Center, L.L.C.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(All sections must be completed)

I hereby authorize the release or disclose to the below-named recipient all of my medical records including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, sexually transmitted disease, or HIV/AIDS infection.

Patient Name: _____ Date of Birth: _____

I hereby authorize the release of medical records to Gastro One from:

I hereby authorize the release of medical records from Gastro One to:

Purpose of disclosure: _____

The authorization will expire on: _____

Date or Event may not exceed one year

This request and authorization applies to:

All medical records
 Health care information relating to the following treatment(s), condition(s) or dates of treatment: _____

Specific records to be released (eg. Labs, imaging reports, other): _____

If you DO NOT WANT certain portions of your medical records released, please initial the box for the information you do not want released.

Substance abuse Psychological or psychiatric treatment HIV/AIDS/STD

I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

Signature of Patient or Authorized Representative

Date Signed

Relationship to Patient