The Gastroenterology Group, PC
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Mail or fax completed forms to:
1939 Roland Clarke Place
Suite 200
Reston, VA 20191
Fax: 571-287-2657

Part 1: Patient Information Name:_____ Date of birth (MM/DD/YYYY): _____

Address:_____ Phone:_____

City:_____ State:_____ ZIP:_____

Part 2: What information are you requesting? (Mark all that apply)

Date(s) of service:_____

☐ Clinic/ Outpatient Record. Clinic:_____ Provider:_____

☐ Inpatient Abstract (includes face sheet, discharge summary, history and physical exam, operative and pathology reports, consultation reports, radiology reports and EEGs)

☐ Discharge Summary
☐ History/Physical Exam
☐ Operative Reports
☐ Pathology Reports
☐ Consultation Reports

☐ Radiology Reports & Images
☐ EKG/Cardiology Reports
☐ Lab Results
☐ Progress Notes
☐ Past/Present Medications

☐ Patient Allergies
☐ Billing (Claim) Information
☐ Other_____
☐ **All health information**

Mental/behavioral health records (may require physician/psychologist approval):
☐Psychiatric/mental health records ☐Neuropsychological testing ☐Other _____

Part 3: Purpose of Disclosure: (Please select only one box)

☐ Personal Use (Skip Part 4 below)
☐ Treatment/Continuing Medical Care
☐ Billing or Claims

☐ Insurance
☐ Legal Purposes
☐ Disability Determination

☐ School
☐ Employment
☐ Other _____

Information Release to: _____
Name of Company/Agency/Facility/Person

_____
Street address

_____
City, state, zip

I hereby authorize the disclosure of the health information from the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with a written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility reviewing it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I signed this authorization.

_____ _____
Signature of individual or guardian or personal representative of patient's estate. POA must be attached — Date

There will be a charge for all Medical Records. VA State rates apply.
Pages 1-50 are $.50 per page, Pages 51+ are $.20 per page,
$7.00 search and handling, plus first class postage