Authorization to Release/Obtain Medical Records

Today's Date:______________

Patient Name:____

PLEASE PRINT

Date of Birth:________________ Phone Number:_______________

Records Released From: (Complete this section in its entirety)

Name:____

Address:____

City, State, Zip:____

Phone:__________________________ Fax:________________________

Records Released To: (Complete this section in its entirety)

Name:____

Address:____

City, State, Zip:____

Phone:__________________________ Fax:________________________

Information to be Released/Obtained

□Complete Medical Record □Lab Reports □Billing Records □Other, please note below:

____

□ I understand that the information in my health record may include information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

□ I understand I have the right to revoke this authorization, in writing, at any time. The revocation will not apply to information that has already been released as a result of this authorization. Unless otherwise revoked, this authorization will expire one (1) year from the signing date.

□ I authorize Tucson Gastroenterology to release or obtain medical records as specified above.

____ ____________________

Patient or Legal Representative Signature Date

____ ____________________

Printed Name of Person Signing Relationship

Tucson Gastroenterology Specialists, PC
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