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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