REQUEST FOR RELEASE OF MEDICAL INFORMATION

Patient Name: ______________________________ Telephone: ________________________________

Date of Birth: ______________________________ Street Address: _____________________________

Last 4 numbers of SSN: ______________________ City, State, Zip: ____________________________

Release records **FROM**:	Release records **TO**:
____ (Facility or medical practice) ____ (Address) ____ (Phone number) (Fax number)	____ (Facility, company, or person) ____ (Address) ____ (Phone number) (Fax number)

Delivery Method: _____ US Mail _____ Fax _____ Pick-up _____ Other method:_________________________________

Specific information to be disclosed (please check appropriate items):

_____ All Records

_____ Office Visit Notes

_____ Operative/Procedure Reports

_____ Test Results (Labs, Radiology, Etc.)

_____ Pathology Reports

Date(s) of Service to be disclosed: From:______________________________ To:___________________________________

This authorization will expire on the following date: ____

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year. I also understand that I may revoke this authorization at any time. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, other communicable diseases, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information.

Patient Rights

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization.

I understand that I have the right to revoke this authorization by sending a written notification to the address below and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in the document. I can do this by written notification to Carolina Digestive Health Associates, PA at one of the addresses listed below.

____

(Signature of Patient or Representative)

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(Date) *(Relationship to Patient)*