CAROLINA DIGESTIVE HEALTH ASSOCIATES, PA REQUEST FOR RELEASE OF MEDICAL INFORMATION

To: _____
(Facility Name) *(Address or Fax Number)*

Patient Name: _____ DOB: _____

I authorize you to disclose the following information from the medical record of the above named patient to Carolina Digestive Health Associates at the address or fax number listed below. The purpose of this disclosure is to provide further medical treatment to the patient.

Specific information to be disclosed (please check appropriate items): _____ All Records _____ Office Visit Notes _____ Operative Reports ____ Test Results (Labs, X-rays, 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 I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.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 Information
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)

_____
(Date) *(Relationship to Patient)*

Please send records via _____ Fax _____ Mail to the attention of Dr. _____ at the Carolina Digestive Health Associates office checked below:

☐300 Billingsley Rd, Ste. 200
Charlotte, NC 28211
Phone: (704) 372-7974
Fax: (704) 372-4966

☐10620 Park Rd, Ste. 102
Charlotte, NC 28210
Phone: (704) 543-7305
Fax: (704) 543-6392

☐1450 Matthews Township Pkwy, Ste. 460 Matthews, NC 28105
Phone: (704) 814-0779
Fax: (704) 814- 0789

☐1663 Campus Park Dr., Ste. D
Monroe, NC 28112
Phone: (704) 291-2488
Fax: (704) 291-7533

☐1223 Spruce Street
Belmont, NC 28012
Phone: (704) 820-9430
Fax: (704) 820-9426

☐8210 University Executive Park Drive, Ste.100 Charlotte, NC 28262
Phone: (704) 547-8818
Fax: (704) 547-9865

☐705 Griffith St. Ste.205
Davidson, NC 28036
Phone: (704) 799-2750
Fax: (704) 799-2760

☐1085 NE Gateway Court Ste. 280
Concord, NC 28025
Phone: (704) 455-9700
Fax: (704) 455-6677

☐Administrative Building
Billing/Medical Records
11301 Carmel Commons Blvd. Ste. 302 Charlotte, NC 28226
Phone: (704) 372-7974
Fax: (704) 943-5091