GASTROHEALTH

Suresh K. Malhotra, M.D., F.A.C.P., A.G.A.F.
Ronald J Barkin, M.D.

4660 Kenmore Ave., Suite 810
Alexandria, VA 22304
Office 703-823-0333
Fax 703-823-8611

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Name: _____ Date of birth: _____

Street Address, City, State, ZIP: _____

Phone Number: _____

I, the above named, hereby authorize that my medical records be released FROM

Physician/Organization/Name:_____

Street Address: _____

_____

I, the above named, hereby authorize that my medical records be released TO

Physician/Organization/Name:_____

Street Address: _____

_____

Information to be released
Complete chart _____

Other (please specify) _____

The purpose of the disclosure of the above information is:
_____ Continuing care
_____ Permanent transfer
_____ Referral
_____ Personal use
_____ At the request of the party above
_____ Other (please specify) _____

_____ I do or _____ I do not consent to the transmission of medical records via facsimile (FAX) machine with the understanding that the confidentiality at the receiving end cannot always be guaranteed.

_____ _____ _____
Printed Name Signature Date