

GASTRO HEALTH



Authorization to release medical records to Gastro Health

PLEASE READ THE FORM CAREFULLY AND FILL OUT COMPLETELY

I AUTHORIZE:

Name of Sending Person/ Organization

Street Address, City, State, Zip Code

Information to be released: Any information including the diagnosis and records of any treatment or examination rendered to me.

RECORDS FROM THE TIME PERIOD: _____ to _____.

PURPOSE OR NEED FOR DISCLOSURE: Continuity of medical care

AUTHORIZATION:

- I understand this consent can be revoked in writing at any time. This revocation will not cover disclosures made previously in reliance on this consent.
- This authorization shall expire 90 days from the date noted below.
- I understand that a reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication

Patient's Name (at time of treatment)

Date

Street Address, City, State, Zip Code

Daytime Phone Number(s)

Signature of Patient or Representative, if Minor

Date

If Representative, Name and Relationship to Patient

PLEASE FORWARD THE INFORMATION TO THE FOLLOWING OFFICE LOCATION

○ 700 Geipe Road, Suite 230 Catonsville, MD 21228 fax: (410) 247-4227

○ 10710 Charter Drive, Suite 110 Columbia, MD 21044 fax: (410) 730-0942

My treatment with Gastro Health is with Dr. _____