GASTRO HEALTH

Authorization to release medical records to Gastro Health Frederick PLEASE READ

THE FORM CAREFULLLY AND FILL OUT COMPLETELY

I AUTHORIZE:

_____

Name of Sending Person/ Organization

_____ _____ _____

Street Address, City, State, Zip Code **PHONE** **FAX**

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 GASTRO HEALTH FREDERICK AT:

O 70 Thomas Johnson Drive Suite 120 Frederick, MD 21702 **Phone: 301-624-5566 Fax: 301-624-5542My treatment with Gastro Health is with Provider:** _____