GASTRO HEALTH

Authorization to Release Medical Records to Gastro Health

PLEASE READ THE FORM CAREFULLLY 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 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 LOCATION:

- ☐ **Annapolis:** 621 Ridgely Ave., Suite 201, Annapolis, MD 21401 • Fax 410-224-4887
- ☐ **Catonsville:** 700 Geipe Rd., Suite 230, Catonsville, MD 21228 • Fax 410-247-4227
- ☐ **Columbia:** 10710 Charter Dr., Suite 110, Columbia, MD 21044 • Fax 410-730-0942
- ☐ **Fredrick:** 70 Thomas Johnson Dr., Suite 120, Frederick, MD 21702 • Fax 310-624-5542
- ☐ **Towson:** 7505 Osler Dr., Suite 502, Towson, MD 21204 • Fax 410-296-1489