Gastro Health - Charlottesville
PATIENT REQUEST FOR ACCESS TO HEALTH INFORMATION

Date: _____ Patient Name: _____

DOB: _____

Patient Address:

_____

_____

Patient Telephone: _____

REQUEST:
I hereby request that Gastro Health - Charlottesville provide me with (check all that apply):

___ Access to ___ My own copy of the requested information checked below:

___ Colonoscopy/pathology reports only

___ My complete medical records

___ My billing records

___ Any other personally identifiable information used by Gastro Health to make medical decisions about me. Please describe:

_____

_____

___ I am interested in access to obtaining a copy of all requested information maintained by Gastro Health.

___ I am interested in accessing or obtaining a copy of the requested information relating to the following time period: _____ through _____

___I would prefer to receive the requested information in the form of a summary prepared by Gastro Health at a cost to me of $_____ (cost will be determined based on complexity of the chart).

___ By requesting these records, I am indicating I am no longer a patient of Gastro Health.

Reason information is being requested: _____

_____

_____
Signature of patient

OR

_____
Signature of Legal Representative/Relation to Patient