GASTROHEALTH

REQUESTING MEDICAL RECORDS FORM

I, the undersigned, request and authorize Gastro Health – Virginia to release the medical information below.

Patient's Full Name _____ Date of Birth _____

Street Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

RELEASE/REQUEST INFORMATION

I am requesting to:

- ☐ Release my medical records
- ☐ Request my medical records

I would like my records sent by:

- ☐ Encrypted Email: _____
  Records will be provided in an encrypted email. If not retrieved within 30 days, records will no longer be accessible, and a new request will need to be submitted.
- ☐ Secure Fax Number: _____
- ☐ Mail (*postage and paper charges may apply)*:

Name/Facility: _____ Attention: _____

Street Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

INFORMATION TO BE RELEASED

Records are requested for (list dates/time period): _____

____ Office Notes ____ Pathology Reports ____ Radiology Reports ____ Entire Chart

____ Procedure Notes ____ Laboratory Reports ____ Specific Test: _____

____ I do ____ I do NOT authorize release of information related to AIDS, HIV, psychiatric, care and/or psychological assessment, treatment for alcohol and/or drugs.

AUTHORIZATION

I understand that if the person or agency that receives my information is not a healthcare provider or health plan covered by the HIPAA privacy regulations, the information described above may be re-disclosed and is no longer protected by these regulations. I understand that written notification is necessary to cancel this authorization and that my cancellation will not be effective as to disclosures already made in reference to this authorization. I understand that Gastro Health providers may not condition treatment on my decision to sign this authorization.

_____ _____

Signature of Patient or Authorized Representative *Date (authorization will expire six months after date signed)*

_____ _____

Printed Name of Patient or Authorized Representative *Relationship to Patient (if applicable)*

PROCESSING FEES

Requests to release information for Insurance and Legal purposes may be processed and invoiced by Ciox. Any other requests to release information will be processed for a fee of $0.50 per page (1-50 pages) and $0.25 per page (50+pages) to cover costs for staff time and materials.

To find your care centers location information, please visit GastroHealth.com