Gastrointestinal Medicine Associates

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Release of Medical Records and Authorization for use or Disclosure of Protected Health Information (PHI)

Patient Information

Patient Name _____ Medical Record Number_____

Address _____

City, State and Zip Code _____ Phone # _____

Date of Birth ____/____/_____ Social Security Number (Last 4 digits only) xxx-xx-_____

I authorize (Provider/Facility):

Name of Person or Facility _____

Practice Address _____ Phone # _____

City, State and Zip Code _____ Fax # _____

To disclose the following information:

- ☐ All Records
- ☐ Office Notes (previous 2 years)
- ☐ Operative Reports
- ☐ Pathology Reports
- ☐ EKG, EEG, EMG
- ☐ Other _____

Please send the records listed about to:

- ☐ Gastrointestinal Medicine Associates, P.C.
  - 3620 Joseph Siewick Drive Suite 307 Fairfax, VA 22033
  - (P) 703-281-1023 (F) 703-620-2331
  - Attention: _____
- ☐ **Other:** _____
  - Address: _____ _____
  - Phone Number _____
  - Fax Number _____

This authorization shall not be valid for greater than one year from the date of signature.

I understand that after GMA discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; or eligibility for benefits unless allowed by law. By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information. I understand that I may revoke this authorization by notifying GMA in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannon be reversed, and my revocation will not affect those actions.

Signature of Patient _____ Patients Date of Birth ____/____/_____

Date of Patient's Signature _____/_____/_____