The Gastroenterology Group
Consent to Release Medical Information

Patient_____ Birthdate_____

Physician/Person releasing records:
Name_____
Address_____
_____
City/State/Zip_____
Phone_____
Fax #_____

Physician/Person to retrieve records:
Martin Shill, M.D., Scott Fulton, M.D.,
Reynaldo Gacad, M.D., Jeffrey Gellis, D.O.,
Dana M. Goodyear, APRN-CNP
570 White Pond Dr, Ste 200
Akron, OH 44320
Phone: 330-869-0954 Fax: 330-869-0964
Records Requested:_____
_____

Medical Information to be sent: (Please initial and sign)

*_____Medical Records, INCLUDING information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment of sexually transmitted disease and HIV/AIDS.

_____ Medical Records, EXCLUDING information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment of sexually transmitted disease and HIV/AIDS.

_____Medical Record of Care from _____to_____ INCLUDING information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment of sexually transmitted diseases and HIV/AIDS.

_____Medical Record of Care from _____to_____ EXCLUDING information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment of sexually transmitted diseases and HIV/AIDS.

*_____If deemed necessary by Doctor_____, I authorize this information to be sent via fax transmission.

This applies to all information in my medical records protected under the regulation in 42 Code of Federal Regulations, Part 2.
I authorize medical information to be released as indicated above. I understand this release is effective until _____. But that I may revoke my consent at any time by providing written consent to the above named party.

*_____ _____
Patient or Patient's Legal Guardian/Authorized Representative Date

_____ _____
Witness Date

_____ _____ _____
If Representative – Relationship Document Reviewed Date