RICHMOND GASTROENTEROLOGY ASSOCIATES

Patient Authorization for Release of Medical Information

Patient's Name: _____

Date of Birth: _____ SS#: _____ Daytime Phone #: _____

I request & authorize _____ to release medical information of the above named patient to:
(Name of Physician or Medical Practice)

Name: _____
(Name of individual or entity to receive the information)

Address: _____

I would like these records: (Please indicate one)

- ☐ Faxed; please provide FAX number: _____
- ☐ Copied on paper

This authorization applies to the following information:

- ☐ All medical records
- ☐ Radiology
- ☐ All Laboratory reports
- ☐ EGD/Path report
- ☐ Colon/Path report
- ☐ Other: _____

This authorization applies to the following time period:

- ☐ Previous ____ years
- ☐ The following dates only: ____/____/____ to ____/____/____
- ☐ No limitations

This protected health information is being used or disclosed for the following purposes: _____
_____
_____

This authorization is effective through: **(check one)**

- ☐ ____/_____/_____
- ☐ No Expiration unless revoked or terminated by the patient or patient's personal representative.

I understand that (1) I have the right to revoke this authorization, in writing, at any time, but that a revocation is not effective to the extent that Richmond Gastroenterology Associates has relied on my authorization. To revoke this authorization, written notification should be sent to Richmond Gastroenterology (Medical Records) at the address listed below. **(2)** Once this information is released by Richmond Gastroenterology Associates, the information may be subject to re-disclosure by the party receiving the information and may no longer be protected by federal or state law. **(3)** Richmond Gastroenterology will not condition my treatment on whether I provide authorization for the requested use or disclosure. **(4)** If applicable, signing this authorization may result in permission for Richmond Gastroenterology Associates to receive direct or indirect payment from a third party based on the use or disclosure of my medical information.

Signature of Patient or Personal Representative: _____ **Date:** _____

Printed Name of Patient or Personal Representative: _____

Description of Personal Representative's Authority: _____

This completed authorization form and any inquiries should be directed to:

Richmond Gastroenterology Associates
Medical Records Department
223 Wadsworth Drive
Richmond, VA 23236

Phone: (804) 560-9877 or (804) 560-9847
Fax: (804) 330-4137

***For office use only**: Patient Chart #* _____ *Revised: 3/10/14*