AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: ____
(FIRST) (M. INITIAL) (LAST)

Address: ____
(STREET)

____
(CITY) (STATE) (ZIP CODE)

Date of Birth: ______/_______ /_______ **Patient Phone**: ____________________

Records Authorized for Release:
Please check appropriate box or boxes:

	COMPLETE RECORD
	PROCEDURE REPORT
	PATHOLOGY REPORT (Bloodwork, Histology, etc.)
	DIAGNOSTIC TEST/ RESULTS (X-RAYs, MRIs, CT scans, and other Radiology Results)
	OFFICE VISIT NOTES

For the dates of service starting: _____ /_____ /_____ through _____ /_____ /_____ .

☐ Check this box for all service dates:

☐ Check this box if you want to ***send*** records to another office or receive a copy for yourself:
I authorize The Gastro Center of Maryland to disclose my health information to:

____.
(Name of Person or Practice)

Fax #: ____________________

☐ Check this box if you want to ***request*** records from another office:

I authorize: ______________________________________ to disclose my health

(Name of Person or Practice)

information to The Gastro Center of Maryland.

Fax #: ____________________

______________________________ ____________________

(Patient Signature) (Date)