

Associates In Gastroenterology
5653 Frist Blvd. Suite 530 Hermitage, TN 37076
Phone: 615-885-1093 fax: 615-885-1110

RELEASE OF MEDICAL RECORDS

PATIENT NAME: _____

Patient DOB: _____

The above mentioned patient was treated in your facility. We would appreciate your sending a resume of the clinical findings, treatments and copies of any surgical procedure notes and radiology reports. Please also indicate any pathology and / or laboratory results.

- | | |
|---|--|
| <input type="checkbox"/> Colonoscopy Report | <input type="checkbox"/> Pathology Report |
| <input type="checkbox"/> EGD Report | <input type="checkbox"/> Laboratory Report |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> Radiology Reports |

PATIENT AUTHORIZATION:

I hereby authorize:

Name: _____	to furnish Name: Associates in Gastroenterology
Address: _____	5653 Frist Blvd Suite 530
	Hermitage, TN 37076
Fax: _____	Fax: 615-885-1110
Phone: _____	Phone: 615-885-1093

The healthcare provider must complete the following:

1. What is the purpose of this disclosure? Medical records review for the purpose of consultation.
2. Will the healthcare provider requesting the authorization receive financial compensation of any kind in exchange for using or disclosing the health information described above? NO

The patient or patient's representative must read and initial the following:

1. I understand that my healthcare and the payment for my health care will not be affected if I do not sign this form. Initials _____
2. I understand that I may see and may receive a copy of the information described on this form if I asked for it and that I will receive a copy of this form after I sign it. Initials _____
3. I understand and agree that this authorizes the release of information concerning HIV testing or treatment of AIDS, AIDS-related conditions, drug or alcohol abuse, drug -related conditions, alcoholism and / or psychiatric or psychological conditions. Initials _____

Must be completed for all authorizations:

The patient or the patient's representative must read and initial the following:

1. I understand that this authorization will expire in one year from the date of signature.
Initials _____
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing. Should I do so, this action will not have any affect on any actions taken by the providing organization before they received the revocation.
Initials _____

Signature of Patient or Patient's Representative

Date

Printed Name of Patient or Patient's representative