GASTROENTEROLOGY AND HEPATOLOGY CENTER
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Phone: 703-724-4480   Fax: 703-724-7743

MEDICAL RECORDS RELEASE / REQUEST FORM

(Check One):

RELEASE _____ Releasing information from us to you or your provider

REQUEST _____ Requesting information from another provider to us

Date: _________________

Name: ____ DOB: __________________________

Address: ____

Phone #: __________________________________ Soc. Sec.#:______________________________________

I authorize the Gastroenterology & Hepatology Center to release / request (circle one) the following:

Information Requested:
____

____

Purpose of the Request:
____

To / From (circle one) Name: ____

Address: ____

Phone #: ____ Fax #__________________________________

- I understand that I have the right to inspect and copy the information to be released.
- I understand that if I refuse to consent to disclosure of information, the agency may be unable to serve me and/or may be unable to provide the most appropriate care for me.
- I understand that the release of information may not be re-released to any other person or organization without my written consent.

Signature: ____ Date:_____________________________