Gastroenterology Associates of Central Va., Inc.
121 Nationwide Drive Suite A
Lynchburg Va., 24502
Office (434) 384-1862 Fax (434) 384-7704

Release of Patient's Medical Record

Patient Name: ___________________________________SSN:_____________________DOB:__________________

AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION **(include name, address, phone and fax)**

☐ **I authorize Gastroenterology Associates of Central Va., Inc. to obtain my health information from:**

____

☐ **I authorize release of my health information from Gastroenterology Associates of Central Va., Inc. to:**

____

☐ **I request a copy of my health information from Gastroenterology Associates of Central Va., Inc.**

For the following purpose(s):____

By initialing the spaces below, I specifically authorize the use or disclosure of the following health information and/or records, if such information and/or records exist:

______Procedure reports
_____ Laboratory reports
_____ Billing Statements
_____ Clinician office chart notes
_____ Transcribed hospital reports
_____ Entire Record (All)
_____ Pathology reports
_____ Medical records needed for continuity of care
Other ___________________
_____ Diagnostic imaging reports
______ Most recent 5-year history (summation)

*** The following items must be initialed to be included in the use or disclosure of other health information:**

______ *HIV/AIDS related health information and/or records
_____ *Mental health information and/or records
_____ *Genetic testing information and/or records
_____ *Drug/alcohol diagnosis, treatment, and/or referral information

(Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information.) ____

Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to: Gastroenterology Associates of Central Va., Inc. 121 Nationwide Drive Lynchburg, Va. 24502. Unless revoked earlier, this authorization will expire 180 days from the date of signing. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization. I also understand that, if the entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.

Records will be mailed to the address on file or may be picked up by the following person(s):___________________________________

____ ______________________________
Signature of Individual or Individual's Legal Representative Date

_______________________________________ _______________________________
Print Name of Legal Representative (if applicable) Relationship of Legal Representative to Individual