Gastrointestinal Associates, LLC
10116 W 105th Street
Overland Park, KS 66212

Phone: 913-495-9600
FAX: 913-307-2009

MEDICAL RECORD RELEASE AUTHORIZATION FORM

Patient Name _____ Maiden Name _____ DOB ___/___/_____

Home # (_____) _____-_____ Cell # (_____) _____-_____ Work # (_____) _____-_____

Address _____ City _____ State _____ Zip _____

Email Address _____

I Authorize Records FROM: ⟹ **To Be Released TO:**

Name _____	Name _____
Address _____	Address _____
City/State/Zip _____	City/State/Zip _____
Phone # _____	Phone # _____
Fax # _____	Fax # _____

This request is being made for the following purpose(s):

Date Range _____ to _____

☐ Physician's Office Notes ☐ Cardiology/EKG Reports ☐ Lab/Pathology Reports

☐ Operative/Procedure Reports ☐ Radiology/XRay/MRI Reports ☐ **ALL** (Notes/Reports)

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an authorized disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____

Date Signature of Patient/Parent/Guardian or Authorized Representative

This authorization will expire one year from the above date unless I specify an expiration date.

_____

(Specified expiration date)