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AUTHORIZATION TO RELEASE/OBTAIN HEALTHCARE INFORMATION

Patient's Name
 (First, Middle, Last): _____ Date of Birth: _____
 Social Security #: _____ Email: _____

I, _____ hereby authorize and request Gastroenterology Associates to release or obtain the medical records related to my illness and/or treatment while under their care to the person/facility listed below.

Please check one: **Release** my GA records to: I authorize GA to **obtain** my records from:

Name of Provider or Facility: _____
**Please complete address, phone # and fax # for provider/facility*
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Phone: _____ Fax: _____

When releasing records to Gastroenterology Associates, send records to:
 Gastroenterology Associates 125 Halton Road, Suite 200 Greenville, SC 29607 Fax (864) 451-5180

Information to be released: (What do you want sent or released?)

- Office Notes Procedure/Pathology Lab Results X-Rays Complete Medical Record
 Financial Records Other: _____

Details/Date Range of Information: _____

Purpose of information:

- Patient Request Transfer of Care Transfer of care is only used for patients that will no longer receive services from Gastroenterology Associates or are transferring care to Gastroenterology Associates.
 Continued Care

- **I understand** that my medical records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). it may also include information about a behavior or mental health service, developmental disabilities, or treatment for alcohol and /or drug abuse.
- **I understand** that information disclosed pursuant to this Authorization might be re-disclosed by the recipient and may no longer be protected by federal or state law.
- **I understand** that I may refuse to sign this authorization and that my refusal to sign in no way affects my ability to receive treatment.
- **I understand** I have the right to revoke this authorization at any time.
- **I understand** I may inspect or copy the protected health information to be disclosed in this document.

Patient Signature: _____ Today's Date: _____

Parent/Legal Guardian/Authorized Person: _____ Today's Date: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

Office Use Only:

Date release mail/faxed to patient/facility:		Sent/Completed By:	
Date release/records received by office:		Release/Records Given To:	
Date records mailed/faxed to patient:		Complete and Sent By:	