GASTROENTEROLOGY ASSOCIATES

125 Halton Rd Suite 200 Greenville, SC 29607
Phone: 864.232.7338
Fax: 864.451.5180

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 Rd 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
☐ Continued Care
☐ 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.

- **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:	