GASTROENTEROLOGISTS, P.C.

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Foley, Alabama 36535
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Medical Records Release Form

PATIENT NAME _____ DOB: _____

ADDRESS: _____

TELEPHONE: _____

I hereby authorize the Medical Records Department at Gastroenterologists, P.C. to release information from my medical record to the following: (If self, please indicate below)

Name of Practice or Doctor:

_____

Address:

_____

For the purpose of (Please check one)

____ Continued Treatment ____ Legal Review _____ Letter ____ Personal review of information
____ Insurance Purpose ____ Entire Record

Covering records from on or about (Date): _____ to _____

CONFIDENTIAL INFORMATION

If the requested portion of the record contains information pertaining to mental health, drug or alcohol treatment, or it contains HIV related information, you must specifically authorize the release of such information by initialing one or both of the following:

_____ I understand that if my record contains information concerning mental health and/or drug and alcohol treatment, such information will be released pursuant to this authorization.

_____ I understand that if my record contains confidential HIV related information, such information will be released pursuant to this authorization form. Confidential HIV related information is any information indicating that a person had an HIV related test, or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has potentially been exposed to HIV. I understand that I do not have to allow release of HIV related information and that I can change my mind at any time before it is released. This authorization will automatically expire within six months from the date of signature. I understand that I have a right to revoke this authorization at any time. The reasonable costs of reproducing copies of written or typed documents or reports shall not be more than:

- One dollar ($1) for each page of the first 25 pages
- Not more than 50 cents ($.50) for each page in excess of 25 pages
- If the medical records are mailed to the person making the request, reasonable costs shall include the actual costs of mailing the medical records

_____ _____
Signature of Patient / Representative / or Legal Guardian Date