Sunil Sarvaria M.D.,Lisa Trail, ANP-BC,
and Dannilyn Kraft, ANP-BC
1115 Dow Street, Suite B Murfreesboro, TN 37130 615.896.6996 phone 615.896.6985 fax

Authorization for Release of Confidential Health Information

Patient name:______________________________ SS#____________________ DOB:______________

Address:__________________________________ City:________________ State:___________

Phone# (____)______-_________

I, the above patient, authorize:

____ To Furnish to: ______To Receive From:

Mid-State Gastroenterology, PLLC (DBA Advanced Health)
1115 B Dow Street
Murfreesboro, TN. 37130
Phone: (615) 896-6996
Fax : (615) 896-6985

____
Name of Healthcare Facility, Physician, Agency, Etc.

____
Address

____
City/ State / Zip

(___)____-__________ (___) ____-__________
Phone Fax

The Following Information:
Check One __________Complete Chart
__________All G.I. Related Records
__________Other:____

For the Following Time Period: From: ________________________To:________________________

This disclosure is made for:____
(Personal Records, Further Care, Transfer of Care, Insurance Legal Counsel, Disability)

- 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 behavioral 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 revoke this authorization at any time by notifying the privacy officer of MSG in writing. Notwithstanding the foregoing, I Understand that I may not revoke this authorization to the extent that MSG has taken action in reliance upon it.
- 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 that this authorization shall expire, without my revocation, on the year following the date of signature unless otherwise indicated.

____
Signature of Patient or Patient Representative Date

____
Signature of Witness Date

For Office Use Only: _____Faxed _____Mailed Date:________________By:________________