

MID-STATE GASTROENTEROLOGY

RELEASE OF MEDICAL RECORDS



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Phone: 615-896-6996

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Website: www.mid-stategastro.com

PATIENT NAME: _____

Patient DOB: _____

The above mentioned patient was treated in your facility. We would appreciate it if you could send the requested clinical findings, treatments and copies of any surgical procedure notes and radiology reports. Please also indicate any pathology and /or laboratory results.

Colonoscopy Report Pathology Report ALL RECORDS
 EGD Report Laboratory Report
 Operative Report Radiology Reports

PATIENT AUTHORIZATION:

I hereby authorize the practice/provider listed below to furnish medical records to _____
_____ at Mid-State Gastroenterology. **If not faxing, please send medical records to Mid-State Gastroenterology at: 1115 B Dow St. Murfreesboro, TN 37130**

Practice/Provider: _____

Address: _____

City, State & Zip: _____

Fax Number: _____

Phone Number: _____

The healthcare provider must complete the following:

1. What is the purpose of this disclosure? Medical records review for the purpose of consultation.
2. Will the healthcare provider requesting the authorization receive financial compensation of any kind in exchange for using or disclosing the health information described above? NO

The patient or patient's representative must read and initial the following:

1. I understand that my healthcare and the payment for my health care will not be affected if I do not sign this form. **Initials** _____
2. I understand that I may see and may receive a copy of the information described on this form if I asked for it and that I will receive a copy of this form after I sign it. **Initials** _____
3. I understand and agree that this authorizes the release of information concerning HIV testing or treatment of AIDS, AIDS-related conditions, drug or alcohol abuse, drug -related conditions, alcoholism and / or psychiatric or psychological conditions. **Initials** _____

Must be completed for all authorizations:

The patient or the patient's representative must read and initial the following:

1. I understand that this authorization will expire in one year from the date of signature. **Initials** _____
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing. Should I do so, this action will not have any affect on any actions taken by the providing organization before they received the revocation. **Initials** _____

Signature of Patient or Patient's Representative

Date

Printed Name of Patient or Patient's Representative