SUBURBAN GASTROENTEROLOGY, LTD.
MEDICAL RECORDS RELEASE AUTHORIZATION

PATIENT INFORMATION:

_____
Name Address City State Zip

_____ (_____)_____ _____
Date of Birth Daytime Phone Previous Name (if applicable)

AUTHORIZES:
Suburban Gastroenterology, Ltd.

TO DISCLOSE TO:

_____

METHOD OF DELIVERY:

☐ Pick-up OR ☐ Mail to address below OR ☐ Fax to number below

Mailing Address: _____

Fax: (_____)_____

INFORMATION TO BE DISCLOSED:

All patient records maintained by Suburban Gastroenterology, Ltd. **The following records will *NOT* be included unless specifically authorized**:

☐ Alcohol/Drug Abuse ☐ HIV Test Results ☐ Mental Health / Developmental Disabilities

EXPIRATION: This Authorization will expire five (5) years from the date signed.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this Authorization. I understand that I may be charged a fee for record copies. In addition, I understand that I do not need to sign this Authorization in order to receive treatment. I also am aware that I may revoke this Authorization at any time in writing; however, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) as authorized by law.

SIGNATURE OF PATIENT / LEGAL REP: _____ **DATE**: _____

If signed by a person other than the patient, complete the following:

1. Individual is: ☐ a minor ☐ legally incompetent or incapacitated ☐ deceased
2. Legal authority: ☐ parent ☐ legal guardian ☐next of kin / executor of deceased ☐ activated POA for Health Care