

GASTROENTEROLOGY SPECIALISTS OF FREDERICK, P.A.

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RELEASE OF INFORMATION REQUEST

I authorize the release of the following records:

- As per the Provider
- Operative/Procedure/Pathology reports
- Records regarding: _____
- All consultant's reports
- All lab and radiology reports

The purpose of the release of this information is (if releasing records **FROM** this practice):

- Continuity of care: records for Primary Care Practitioner, consultation with another physician, etc.
- Transfer of care: leaving this practice; effective date (if not date below): _____
- Transfer of care due to insurance change or leaving this area; Effective date (if not date below): _____
- Legal: injury or worker's compensation. Legal: other, please specify _____
- Other, please specify _____

TO:

FROM:

THE MEDICAL RECORDS RELEASED MAY CONTAIN INFORMATION PERTAINING TO PSYCHIATRIC, HIV (AIDS), SEXUALLY TRANSMITTED DISEASES, DRUG AND/OR ALCOHOL DIAGNOSIS AND TREATMENT. I RELEASE THE DOCTORS, AGENTS, AND EMPLOYEES FROM ALL LEGAL RESPONSIBILITY OR LIABILITY FOR ANY ACTIONS OR OMISSIONS THAT MAY RESULT FROM THIS AUTHORIZATION. A COPY OR FACSIMILE OF THIS FORM SHALL BE AS VALID AS THE ORIGINAL.

This authorization is valid for one (1) year. Please fax reply 301/663-4602 YES / NO

(printed name) _____

(signature) _____

(date of birth) _____ (last 4 digits of ss#) _____ (date signed) _____

Maryland law, Health-General Article section 4-304(c)(3), as of 2013 allows: copying charge of \$.76 per page, processing fee of \$22.88 if faxing or the actual cost of shipping and handling if mailed.

FOR OFFICE USE:

Records to be sent via (circle one): Pt. pick up/ Fax/ Mail

Number of pages _____ Charge for records _____ Paid? _____