GASTROENTEROLOGY SPECIALISTS OF FREDERICK, P.A.
85 THOMAS JOHNSON COURT SUITE B
FREDERICK, MD 21702-4331
Phone 301.663.9440 Fax 301.663.4602
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RELEASE OF INFORMATION REQUEST

I authorize the release of the following records:

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

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:

_____ ____________________________________
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____

FROM:

_____ ____________________________________
____
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____

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? ______