GASTROINTESTINAL HEALTHCARE
Improving Your Health From The Inside Out.
2011 Falls Valley Drive, Suite 106, Raleigh, NC 27615
Phone: 919-870-1311 Fax: 919-881-0822
www.giraleigh.com

Patient's name:____________________________ Date of Birth:_________________________

Social Security Number:____________________ Telephone number:_____________________

Address:____

☐ This form authorizes ____ to fax my medical records to GastroIntestinal Healthcare at (919) 881-0822.

Specific records requested: ____

☐ Please release my medical records from GastroIntestinal Healthcare to:

Provider/facility name: ____

Address: ____

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Phone # ____________________________ Fax #______________________________

Please release all records, including but not limited to: progress notes, operative notes, laboratory test results, diagnostic tests and x-rays.

Expiration date of authorization: This authorization is effective for one year from the date signed unless revoked or terminated by the patient or patient's representative.

Right to terminate or revoke authorization: You may revoke or terminate this authorization by submitting a written revocation to GastroIntestinal Healthcare. You should contact the Privacy/Compliance Officer to terminate this authorization.

Potential for re-disclosure: Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under Federal Privacy Regulations.

No conditions on treatment or payment: GIH will not condition the provision of treatment or payment on the provision of this authorization.

I hereby authorize the release of my medical records as provided above.

____ Date:_______________________

Patient's Signature