GastroIntestinal Healthcare
Improving Your Health From The Inside Out.
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Patient Self Release Access Form

Patient name:_______________________________________ Date of birth:______________

Social security number:______________________ Telephone number:__________________

Address:____

Email Address:_______________________________

Name at time of treatment, if different than above:___________________________________

What records are you requesting? Please describe exact nature and dates of medical records that you would like.

	Date(s)		Date(s)
Office Visit		Pathology Report	
Itemized Bill		Laboratory Result	
History & Physical exam		Diagnostic Test	
Procedure Report		Radiology Report	
Discharge Summary		Other	
Other Provider Note		Other	

It is our policy to provide specific requested patient medical records to patients through their secure Patient Portal.

If you prefer your medical records in a different format, please indicate your preferred method of delivery. Secure Email ___; Mail ___: Pick-up paper copies ___: Fax: ___: USB ___
Please be aware you are responsible for the cost of paper copies of your medical records in excess of 10 pages. Additional pages will be charged at $0.50/ page.

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

_______________________________________ ______________________
Patient's Signature Date Requested:

For Office Use Only

Records Released Date:________________ Documentation completed by_________________

Manner Provided_____________________