



**GASTROENTEROLOGY  
ASSOCIATES OF  
TIDEWATER, P.C.**

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 Brian M. Sullivan, M.D.

**MEDICAL RECORDS RELEASE**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Account #: \_\_\_\_\_

Patient Social Security Number: \_\_\_\_\_

**At the request of the above named individual, please Release Records to:**

**Gastroenterology Associates of Tidewater,  
5701 Cleveland St., Suite 100,  
Virginia Beach, VA 23462**

(757) 547-0798  
Phone Number

(757) 547-0145  
Fax number

**Request records from:**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address, City, State & Zip

(\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Phone Number Fax number

**Information Requested for medical treatment:**

**All medical records:** without exception, including progress notes, lab reports, consultations, hospital notes, procedure/operative reports.

**Partial medical records:** Check which records are being requested  
 progress notes lab reports Consultations Hospital notes  
 procedure/operative report Other(specify) \_\_\_\_\_

I hereby authorize the use or disclosure of my protected health information (PHI) as described above. I understand that this authorization is voluntary. I understand that ability to obtain treatment will not be affected if I do not sign this form, unless that treatment is for a fitness-for-duty evaluation or a research-related treatment. I understand that if they organization authorized to receive the information is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and will no longer be protected. I understand that I have the right to revoke this authorization by sending written notification to Tidewater Gastroenterology, PLLC, 112 Gainsborough Square, Suite 200; Chesapeake, VA 23320. Any revocation will not affect disclosures made prior to Tidewater Gastroenterology's receipt or knowledge of the revocation. Unless I revoke this authorization prior to such a time, this authorization shall expire: \_\_\_\_\_ (90 days if left blank) from the date of my signature. I understand that I have the right to inspect and receive a copy of the information described on this form.

\_\_\_\_\_  
Signature of patient or patient's authorized representative **Date**

\_\_\_\_\_  
Printed name of patient's representative (if applicable) Relationship to patient

**Norfolk Office**  
160 Kingsley Lane, Suite 200  
Norfolk, Virginia 23505  
(757) 889-6800  
Fax (757) 547-0145

**Virginia Beach Office**  
5701 Cleveland Street, Suite 100  
Virginia Beach, VA 23462  
(757) 547-0798  
Fax (757) 547-0145

**Chesapeake Office**  
112 Gainsborough Square, Suite 200  
Chesapeake, Virginia 23320  
(757) 547-0798  
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