GATGI
Gastroenterology Associates of Tidewater
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MEDICAL RECORDS RELEASE

Patient Name:
Date of Birth:
Patient Social Security Number:

Request Records from:

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

(757) 547-0798 Phone Number
(757)547-0145 Fax number

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

_____
Name

_____
Address, City, State & Zip

(_____)_____ (_____)_____
Phone Number Fax number

Information Requested for medical treatment and continuity of care:

- **All medical records**: without exception, including progress notes, lab reports, consultations, hospital notes, procedure/operative reports.
- **I understand information to be released includes information regarding the following conditions:**
  - Drug Abuse • Alcoholism or alcohol abuse • testing for or infection with human immunodeficiency virus (HIV) • Sickle cell anemia
- **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 no 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