Alan J. Gamsey, MD, FACP, FACG, AGAF
Felix P. Tiongco, MD, FACP
Walid F. Makdisi, MD
Brian M. Sullivan, MD
Shoba Mendu, MD
Rene J. Rivera, MD
Jeremy P. Domanski, MD
Katelyne Hale, PA-C
Amber Stewart, PA-C
Ashton Dear-Huffman, PA-C

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

X **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