

RELEASE OF MEDICAL RECORDS REQUEST

Patient: _____ Date of Birth: _____

Street: _____

City: _____ State: _____ Zip Code: _____

To Doctor/Medical Practice: Gastroenterology Specialists Inc.

Street: 45 Wells Street Suite 103

City: Westerly State: RI Zip Code: 02891

Phone: (401) 596-6330 Fax: (401) 348-0420

I hereby authorize and request that you release my medical records to:



PAMELA J. CONNORS, MD PC
Gastroenterology and Digestive Wellness
20 South Anguilla Road, Suite 12
Pawcatuck, Connecticut 06379
(860) 495-5720 Fax (860) 495-5584

Include the following health records concerning my prior evaluation, illness and/or treatment:

- | | | |
|--|---|--|
| <input type="checkbox"/> Complete health records | <input type="checkbox"/> X-Ray reports | Sensitive Records: |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Laboratory reports | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Consultation notes | <input type="checkbox"/> Operative reports | <input type="checkbox"/> Psychiatric |
| <input type="checkbox"/> Procedure notes | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Substance abuse |

Covering the period:

Date From: _____ Date To: _____

The Health Insurance Portability and Accountability Act, HIPAA, set forth the circumstances under which a Health Care Provider must obtain an individual's authorization before it uses or discloses Protected Health Information (PHI). This authorization may be required for the Health Care Provider's own purposes, or because the individual has made a specific request for the use and disclosure of the PHI. I understand this authorization may be revoked in writing at any time, except to the extent that the disclosure made in good faith has already occurred in reliance of this authorization. Unless otherwise specified, this authorization will expire on: _____

Signature: _____ Date: _____

If relative, print name and state relationship: _____