Gastroenterology Associates **216 Southpark Circle East, St. Augustine, FL 32086**
St. Augustine Endoscopy Center **212 Southpark Circle East, St. Augustine, FL 32086**
Tel (904) 824-6108 **Fax (904) 823-9613**

GI REQUESTING INCOMING MEDICAL RECORD RELEASE

Patient Information

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Address _____ Date of Birth: _____

Home Phone _____

_____ _____ _____
City State Zip

I, _____, do hereby consent to and authorize _____
Patient's Name/Guardian Name of Provider/Hospital/Insurance Company/Other Agency

located at _____
Address City State Zip

to disclose to **____Santiago A. Rosado, MD; ____Steven Y. Villanueva, MD; ____Timothy J. Cavacini, DO; ____Stuart A. Soroka, MD;____Daniel J. Gassert, MD; ____William J. Barlow, MD; ____Anis A. Ahmadi; ____Camille A. McGaw, MD**

for the purpose of continued medical care:

my individually indentifiable health information (protected health information) as described below. I understand that this authorization is voluntary. I understand that I may refuse to sign this authorization. I understand that my health care and the payment for my health care will not be affected if I do not sign this form.

The information to be released is:

- ☐ **History & Physical**
- ☐ **Pathology Report**
- ☐ **Operative Reports**
- ☐ **Other (Please Specify)**
- ☐ **Discharge Summary**
- ☐ **Consultation Report**
- **(GI Procedures-Colonoscopy, EGD,FS,ERCP)** _____
- ☐ **Laboratory Results**
- ☐ **X-Ray Report**
- ☐ **EXCEPTION: I do not give permission to release (please specify):** _____

I authorize the release of my protected health information related to the categories below: (Signatures required)

_____ _____ **Mental Health Records**
Signature **Date**

_____ _____ **Communicable diseases (including HIV and AIDS)**
Signature **Date**

_____ _____ **Alcohol/drug abuse treatment**
Signature **Date**

I understand that I may revoke this authorization at any time by notifying the providing organization in writing. Should I do so, this action will not have any affect on any actions taken by the providing organization before they received the revocation. **Initials**: _____

I understand that my authorization will expire on _____/_____/____ or 90 days from date of my request. **Initials:** _____

_____ _____ _____ _____
Signature of patient or patient's representative Printed name Relationship (if applicable) Date/Time

_____ _____
Name of physician requesting records (Required for Veterans Administration) Physician Signature (Required for Veterans Administration)

_____ _____
Witness to Signature Date/Time

☐ Unable to sign because: _____

PATIENT: ☐ received ☐ refused a copy of this form