San Francisco Gastroenterology
Medical Records Release Request Form

Please complete the following information:

Patient Name: ____
Address: ____
____
Daytime Telephone Number: ____
SSN: ____________________________________Date of Birth:_______/_______/________

I authorize the custodian of records of San Francisco Gastroenterology or other person/entity (specifically describe)___________________________ to disclose/release the following information* (check all applicable):

o All records
o Laboratory/pathology records
o X-ray/radiology records
o Billing Records
o Pharmacy/prescription records
o Other:____________________________

***Note:** *If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

These records are for services provided on the following date(s): ____

Please send the medical records listed above to:
Name: ____
Address: ____
____
Phone: ___________________________________ Fax: ____________________________________

The information may be used/disclosed for each of the following purposes:
o At my request (only the patient can check this box)
o For further medical care
o Other:____
o For payment/insurance
o For employment purposes

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is by my request to release my medical records to the entity or facility listed above. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information. I understand that by signing this release form, if I have requested a copy of my medical records previously, that there may be a charge for an additional copy.

____
Signature of patient (or patient's personal representative)

____
Date

____
Printed name of patient representative

____
Representative's authority to sign for patient, *(i.e parent,guardian, power of attorney for healthcare, executor)*