Gastroenterology Associates of Rochester, LLP
2440 Ridgeway Ave, Suite 100, Rochester, NY 14626
Phone: 585-720-1550 Fax: 585-225-3745

Authorization for Release of Medical Records (PHI)

Patient's Name: _____ Date of Birth: _____
Address: _____
City/State/Zip Code: _____
Phone #: ( )_____

Date of Request: _____ Date Needed: _____

I authorize Gastroenterology Associates of Rochester, LLP to

RELEASE information **to**:	**OBTAIN** information **from:**
_____	_____
Name of Provider or Facility	Name of Provider or Facility
_____	_____
Address	Address
_____	_____
City, State, Zip Code	City, State, Zip Code
_____/_____	_____/_____
Phone # / Fax # (include area code)	Phone # / Fax # (include area code)

PURPOSE FOR THIS REQUEST: (Circle one) Transfer (Specify reason) _____
2nd Opinion Insurance Other (Specify)_____

TYPE OF PHI REQUESTED: (Circle all that apply) Procedure Reports Progress Notes Labs
X-Rays Other (Please Specify)_____

All PHI related to a specific illness or injury: _____
(Please specify)

I understand that:

. My right to healthcare treatment is not conditioned on this authorization.

. I may cancel this authorization at any time by submitting a ***written*** request to the address provided at the bottom of this form, except where a disclosure has already been made in reliance from my prior authorization.

. If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations the information stated above could be re-disclosed. (If you are not the intended recipient, or the agent responsible to deliver to the intended recipient, you are hereby notified that any disclosure, copying or distribution of this information is ***strictly prohibited***.)

. There may be a charge for the requested records.

Signature of Patient or Representative_____ Date_____

Relationship to Patient (if requestor is not the patient)_____

Rev. 05/18/13