# Gastroenterology of the Rockies Authorization for the Release Of Medical Records

## What Location or Doctor are the records coming from?

Location/Doctor's Name:

## Tell us about the patient.

Name: DOB: SSN: XX-XX-

Email:

Address:

City: State: Zip:

Phone#: Fax#:

## Where are we sending the records?

Name:

Email:

Address:

City: State: Zip:

Phone#: Fax#:

## What would you like released?

### Specific Categories

☐ All Records ☐ Office/Clinic Notes ☐ Operative Reports

☐ Lab/Pathology Results ☐ Radiology Reports ☐ Immunization Records

☐ Dates _____ to _____ ☐ Other_____

If you do not want certain portions of your medical records released, please check the categories listed below you would like excluded.

☐ Substance Abuse, if any ☐ AIDS/HIV/STDs, if any ☐ Psychological/Psychiatric conditions, if any

## Why are we sending the records?

### Purpose of Disclosure

Personal Use □ Litigation/Legal □ Insurance □ Transfer of Care/Continuation of Care

## How would you like the records sent?

### Delivery Method*

Email ☐ Fax ☐ Pick-Up ☐ Postage ☐

## Patient's Signature

I hereby authorize Medi-Copy and its affiliates to release or disclose to the person(s) or organization listed above, all medical records requested, including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia or HIV infection, *unless otherwise noted*. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the recipient on this request and will no longer be protected by federal regulations.

Patient's Signature: Date:

Relationship to patient: