

Gastroenterology Associates of Central Va

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Authorization to Release or Obtain Medical Information

Patient Name: _____ Chart Number: _____

Date of Birth: _____ Social Security Number: _____

I hereby authorize the release of my complete medical information as indicated by the checkmark(s) below.

- Complete Record
- Records of care from the following dates: _____ to _____
- Records concerning only the following conditions: _____
- Other (please specify): _____

Release Medical Records to Myself

Release Medical Records to the following:
or

Obtain Medical Records from the following:

Name: _____

Street: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

- ❖ I understand that I may revoke this authorization at any time in writing. Revoking will not affect uses or disclosures of my confidential information that occurred prior to revoking. Any limitations in confidential information released must be noted above. I understand that there may be a fee charged according to rulings set forth by the Virginia Statutory Code and I agree to be responsible for and pay the fee for providing copies of my medical information. If applicable, I certify that I am Legal Representative to above named patient and will provide a POA, Death Certificate, etc.

Patient Signature: _____ Date: _____