GASTRO HEALTH

703-698-8960
GastroHealth.com/Virginia

REQUEST FOR MEDICAL RECORDS RELEASE

I, the undersigned, request and authorize Gastro Health – Virginia to release the medical information below.

Patient's Full Name _____ Date of Birth _____

Street Address _____ Home Phone _____

City _____ State _____ Zip _____ **Daytime** Phone Number _____

Release Information To

☐ Mail to patient at above address (postage charge will apply)

☐ Send to patient through the Gastro Health portal *(there is no charge for this delivery method.)*

☐ Send to:

Name/Facility _____ Attention _____

Street Address _____ Phone _____

City _____ State _____ Zip _____ **Fax** _____

Purpose of Request

___ Referral to Specialist ___ Workers Comp ___ Disability Determination ___ Leaving Practice
___ Insurance ___ Personal Records ___ Legal Investigation ___ Other

Information to be Released

Records are requested for (list dates/time period) _____

__ Office Notes ___ Pathology Reports ___ Radiology Reports ___ Specific Test __
__ Procedure Notes ___ Laboratory Reports ___ Entire Chart

Please indicate below how protected information should be handled, even if the categories do not apply to the patient's medical records.

___ **I do** ___ **I do NOT** authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infections, psychiatric care and/or psychological assessment, treatment for alcohol and/or drug use.

Authorization

I understand that if the person or agency that receives my information is not a healthcare provider or health plan covered by the HIPAA privacy regulations, the information described above may be re-disclosed and is no longer protected by these regulations. I understand that written notification is necessary to cancel this authorization and that my cancellation will not be effective as to disclosures already made in reference to this authorization. I understand that Gastro Health providers may not condition treatment on my decision to sign this authorization.

Signature of Patient or Authorized Representative _____ Date (Authorization will expire six months after date signed) _____

Print Name of Patient or Authorized Representative _____ Relationship to Patient _____

Processing Fees

Requests for **Insurance** and **Legal** purposes will be processed and invoiced by **Healthport**. For all other requests, Gastro Health will process the **first medical records release to one recipient** at no charge. Subsequent requests/recipients will be processed for a fee of $0.50 per page (1-50 pages) and $0.25 per page (50+pages) to cover costs for staff time and materials. (There is no charge for records delivered via Gastro Health portal.)

Mail or fax this request to: Gastro Health Medical Records, 3028 Javier Road, 5th Floor, Fairfax, VA 22031
Fax: 571-494-5794