GANV
GASTROENTEROLOGY ASSOCIATES OF NORTHERN VIRGINIA
Leaders in gastrointestinal and liver care.

703-698-8960
wwww.myGANV.com

# REQUEST FOR MEDICAL RECORDS RELEASE

I, the undersigned, request and authorize Gastroenterology Associates of Northern 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 GANV portal *(there is no charge for this deliverymethod.)*
☐ Send to:

Name/Facility________________________________________ Attention ____________________________

Street Address________________________________________ Phone ____________________________

City__________________________ State________ Zip__________ **Fax** ____________________________

## Purpose of Request

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

## Information to be Released

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

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

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 GANV 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, GANV 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 GANV portal.)

<u>Mail or fax this request to</u>: GANV Medical Records, 3028 Javier Road, 5th Floor, Fairfax, VA 22031
Fax: 571-494-5794