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

703-698-8960
wwww.myGANV.com

REQUEST FOR MEDICAL RECORDS RELEASE TO GANV

Attention (Physician/Facility) _____ Phone _____

Address _____ Fax _____

City/State/Zip _____

Please release medical records for the following patient to Gastroenterology Associates of Northern Virginia (GANV).

Patient Name _____ Date of Birth _____

Patient is currently being seen at GANV by:

- ☐ Kenneth Mirkin, MD
- ☐ Michael Garone, MD
- ☐ Peter Scudera, MD
- ☐ Byungki Kim, MD
- ☐ Tonya Adams, MD
- ☐ Jeremias Tan, MD
- ☐ Ahmed Hegab, MD
- ☐ Asma Khapra, MD
- ☐ Nader Balba, MD
- ☐ Behzad Kalaghchi, MD
- ☐ Carol Schuffler, MD
- ☐ Mahmood Abedi, MD
- ☐ Beza Tekola, MD
- ☐ Rupa Shah, MD
- ☐ Felice Banson, MD
- ☐ Ivan Harnden, MD
- ☐ Iris Lee, MD
- ☐ Emarie Hill, PA-C
- ☐ Hanna L. Kim, PA-C
- ☐ Stephanie Byers, PA-C
- ☐ Lindsey A. Sullivan, PA-C
- ☐ Kristin Maggi, PA-C
- ☐ Danielle Layton, PA-C
- ☐ Daniela Da Rocha, PA-C
- ☐ Rebecca Dieterich, PA-C
- ☐ Lindsay Tom, PA-C
- ☐ Angela Russell, PA-C

Records are requested for the following time period: _____
Please include:

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

Patient Authorization:

I, the undersigned, authorize the release of the medical records indicated above, to be faxed or mailed to Gastroenterology Associates of Northern Virginia.

___ 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.

_____ _____
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

Please fax records to: 571-494-5794