GASTRO HEALTH

703-698-8960
GastroHealth.com/Virginia

REQUEST FOR MEDICAL RECORDS RELEASE

Attention (Physician/Facility)_____ Phone _____

Address_____ Fax _____

City/State/Zip _____

Please release medical records for the following patient to Gastro Health – Virginia.

Patient Name_____ Date of Birth _____

Patient is currently being seen at Gastro Health 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
- ☐ Mahmood Abedi, MD
- ☐ Beza Tekola, MD
- ☐ Ivan Harnden, MD
- ☐ Iris Lee, MD
- ☐ Nitin Sardana, MD
- ☐ Nicholas Szary, MD
- ☐ Mohamed Sultan, MD
- ☐ Vishant Ramadorai, MD
- ☐ Javelle Wynter, MD
- ☐ Heather Greenberg, PA-C
- ☐ Joanna May, PA-C
- ☐ Melissa Nickols, PA-C
- ☐ Anastasia Grebeck, PA-C
- ☐ Brittany Stivers, NP-C
- ☐ Lindsay Casola, PA-C
- ☐ Emarie Hill, PA-C
- ☐ Hanna Kim, PA-C
- ☐ Dana Fayyad, PA-C
- ☐ Nicole Dease, PA-C

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

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

Patient Authorization:

I, the undersigned, authorize the release of the medical records indicated above, to be faxed or mailed to Gastro Health.

___ **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