MITTAL
Gastroenterology & Rheumatology

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Medical Records Release Request Form

Please complete the following information:

Patient Name: _____ DOB: _____

Address: _____

Phone Number: _____ SSN: _____-_____-_____

I authorize the custodian of records of Mittal Gastroenterology & Rheumatology or other person/entity (specifically describe)

_____ to disclose/release the following information* (check all applicable):

- ☐ All records
- ☐ X-ray/radiology records
- ☐ Billing Records
- ☐ Laboratory/pathology records
- ☐ Pharmacy/prescription records
- ☐ Other: _____

***Note**: If the records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

These records are for services provided on the following date(s): _____

Please send the medical records listed above to:

Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

The information may be used/disclosed for each of the following purposes:

- ☐ At my request (only the patient can check this box)
- ☐ For further medical care
- ☐ Other: _____
- ☐ For payment/insurance
- ☐ For employment purposes

I understand that after the custodian of records discloses my protected health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is by my request to release my medical records to the entity or facility listed above. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information. I understand that by signing this release form, if I have requested a copy of my medical records previously, that there may be a charge for an additional copy.

_____ _____

Patient Signature (or patient's representative) Date:

_____ _____

Printed Name of Patient
(or patient's representative)

Representative's authority to sign for patient
(i.e. parent, guardian, power of attorney, executor)