Gastroenterology and
Internal Medicine Specialists, S.C.

A division of GI PARTNERS of ILLINOIS, LLC

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REQUEST FOR RELEASE OF MEDICAL RECORDS

_____ ***Please send my medical records to the following physician:***
_____ ***Please obtain my medical records from the following physician:***

Physician's Name (print) _____

Address _____

City _____ State _____ Zip _____

Physician's Phone Number _____ Fax _____

_____ ***Please provide a copy of my records to me by***:

_____ Faxing to me at fax #_____

_____ Mailing a paper copy to the address below

_____ Holding a paper copy for pick-up in your

Barrington / Woodstock / McHenry/Huntley office (circle one)

Patient's Name (print) _____ Date of Birth _____

Patient's Signature _____Today's Date_____

Address _____ Phone Number _____

City _____ State _____ Zip _____

Records Requested _____Date Picked Up/Office_____

Records Exclusion *_____Date Mailed/Faxed_____

THIS RELEASE IS VALID FOR ONE YEAR FROM THE DATE SIGNED.
The patient has the right to revoke this authorization in writing to the above office. Although this is a HIPAA compliant office, and every effort is made to safeguard the confidentiality of patient records, I hereby release Gastroenterology and Internal Medicine Specialists, S.C. from all liability and all claims of any nature whatsoever pertaining to disclosure of information contained in my medical records.
*Under some circumstances, a patient has the right to exclude parts of their records that pertain to HIV/AIDS, mental conditions, genetic testing, or any form of substance abuse unless directly related to the above Doctors' testing and treatment. 12/16