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REQUEST FOR RELEASE OF MEDICAL RECORDS
Complete Patient information ONLY

Patient's Name (print) ______________________ Date of Birth ______________

Patient's Signature _________________________Today's Date_______________

Address _____________________________ Phone Number __________________

City ______________________ State _______________ Zip _________________

FOR DOCTORS OFFICE TO COMPLETE

_____***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)

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. 1/17/19

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