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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 OFFICE USE ONLY (DO NOT FILL OUT)

_____ *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 above

_____ Holding a paper copy for pick-up in your office

Barrington / McHenry / Huntley-Suite 210 / Huntley-Suite 115 (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