Dale Coy, MD
Manish Bhuva, MD
Dafna Gordon, MD
Amit Shah, MD
Chad Spangler, MD

Brant Lutsi, MD
Nicole Gentile, MD
Erin Micklinghoff, CNP
James Ferguson, CNP
Katie Akers, CNP
Mary Joyce Lagatao, CNP

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 / Crystal lake (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