



Physicians Endoscopy Center

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's name: _____ Date of Birth: ____/____/____

Address: _____

City/State/Zip Code: _____

SS#: _____ Patient's phone #: (____) _____

Date of Request: ____/____/____ Date Needed: ____/____/____

I authorize Physicians Endoscopy Center **to release my medical information to:**

Name of Provider or Facility: _____

Address: _____

City/State/Zip Code: _____

Phone #: (____) _____ Fax #: (____) _____

PURPOSE FOR THIS REQUEST (check one):

- Further medical care Legal investigation Insurance claim payment Transfer of care
 Personal Other: _____

TYPE OF RECORDS REQUESTED (check one):

- All medical records related to a specific illness/condition:
Specify illness/condition _____ Date(s) of Procedure _____
- Specific information (Select one or more, as applicable):
 History & physical Pathology/laboratory test results
 Procedure report Other: _____

- Complete copy of all records.

AUTHORIZATION VALID FOR (check one):

- This request only.
- One year from the date of this authorization **OR** ____/____/____. This authorization applies to the records of the treatment received on or prior to the date of this authorization.
- This request **and** for medical records of any **future** treatment of the type described above until: ____/____/____

I understand that:

- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- The information I authorize for release may include information regarding mental health, drug or alcohol use/abuse, communicable diseases, pregnancy, and HIV/AIDS.
- There may be a charge for the requested records.

Patient/Representative Signature: _____ Date ____/____/____

Relationship to Patient (if requester is not the patient) _____