REGIONAL GASTROINTESTINAL ASSOCIATES OF LANCASTER

Patient Authorization for Release of Medical Records

Return to contact@cgi-health.com or fax to 215-257-1801

Patents Name: ____ DOB : _____________________

Address: ____

Please check all information that applies.

- ☐ Chart Notes
- ☐ MRI Reports
- ☐ X Rays
- ☐ CAT Scan
- ☐ Other (please specify): __________________________

☐ I give my authorization to release the above protected information to Regional Gastrointestinal Associates of Lancaster.

☐ I am authorizing Regional Gastrointestinal Associates of Lancaster to disclose or release the above protected information to the following person or organization. The following will receive and use my protected health information:

NAME ____

ADDRESS ____

FAX ____

Select one of the following choices:

☐ This authorization will end on the following date: ______________

☐ This authorization will end when the following event happens The event must relate to the individual or the purpose of the authorized us/or disclosure. Describe the event below:

Signature of Patient

Name of Patient

Date: