



Pramod Malik, MD
FACG, FASGE, AGAF, CPI
Board Certified in Gastroenterology

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name in full:

Other names (Aliases):

Date of Birth:

Social Security #:

Reason for disclosure: (Check one) Medical care Second opinion Transfer of care Other _____

Entity FROM whom the information is requested:

Physician/ organization: Gastroenterology Associates of Tidewater (A Division of Tidewater Gastroenterology)

Street Address: 112 Gainsborough Square, Suite 200

City: Chesapeake

State: VA

Zip: 23320

Tel: 757-547-0798

Fax: 757-547-0145

Entity TO whom the information is to be sent to:

Physician/ organization: Pramod Malik, MD – Virginia Gastroenterology

Street Address: 2790 Godwin Blvd; Suite 205

City: Suffolk

State: VA

Zip: 23434

Tel: 757-942-2566

Fax: 757.932.9279

Information requested:

___ Progress & consult notes (In/Outpt)

___ Other _____

___ Endoscopic procedure & Path reports

___ Operative procedure notes

___ Lab reports

___ CT/MRI/MRCP/ US/ radiology procedures

1. I hereby authorize and request release of my above Protected (individually identifiable) Health Information to **Virginia Gastroenterology Institute, PC (VGI)**.
2. I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse, and/or HIV/AIDS test results or diagnoses.
3. I understand that I may revoke this authorization at any time by notifying the releasing organization in writing but it does not affect the information already received by **VGI**. I understand that if the organization authorized to receive the information is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and will no longer be protected.
4. I understand that this authorization is voluntary and that I do not have to sign this authorization. My refusal to sign will not affect my ability to obtain treatment.

Signature of patient or patient's representative

Date

Printed name of patient's representative

Relationship to the patient

(This form MUST be completed before signing)

Form Last Updated: March 2018