Pramod Malik, MD, FACG, FASGE, AGAF
Hemchand Ramberan MD, FACG, FASGE
Ashley Alexander, FNP-C
Tierra Wiggins, FNP-C

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: *Virginia Gastroenterology Institute*

Street Address: *3910 Bridge Rd., Suite 101*

City: *Suffolk* ***State:*** *VA* ***Zip:*** *23435*

Tel: *757-942-2566* ***Fax: 855-313-1070***

Information requested:

___ *Progress & consult notes (In/Outpt)*
___ *Endoscopic procedure & Path reports*
___ *Lab reports*
___ *Other* _____
___ *Operative procedure notes*
___ *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*