GI Alliance

Authorization to Release Medical Records to Third Party

I hereby authorize _____ d/b/a GI Alliance on behalf of itself and all other practices that are operation as a single HIPAA affiliated Covered Entity (collectively "Provider") to transfer, release, or obtain information on:

_____ (Name of Patient) _____ (Date of Birth) _____ (Last 4 Digits of SSN)

OBTAIN FROM: (DO NOT LEAVE BLANK)	DISCLOSE TO: (DO NOT LEAVE BLANK)
☐ Provider: _____	_____ Individual/Name of Entity
☐ All GI Alliance (select if seen by multiple providers)	_____ Address
_____ Address	_____ City, State, and Zip
_____ City, State, and Zip	_____ Phone
_____ Phone	_____ Fax
	Delivery Method: ☐ E-Delivery ☐ Mail

For the Purpose of:

- ☐ Continuing Medical Care
- ☐ Insurance
- ☐ School
- ☐ Military
- ☐ Legal Purposes
- ☐ Social Security/Disability
- ☐ Patient's Request
- ☐ Other (specify)

Date(s) of Treatment: ☐ Specific Dates: _____ thru _____ ☐ All Dates

Please Check Specific Information Request

- ☐ All Records
- ☐ Abstract Record*
- ☐ Medication Records
- ☐ Laboratory/Pathology Reports
- ☐ Radiology Reports
- ☐ Verbal Communication Only
- ☐ Office/Progress Notes
- ☐ Operative Notes
- ☐ Itemized Billing Statements
- ☐ Other (Specify) _____

I understand that my records may contain but are not limited to: history, diagnosis, and/or treatment of sexually transmitted diseases, drug and/or alcohol abuse, mental illness, psychiatric treatment, or genetic counseling. By initialing, I give my specific authorization for these records to be released:

- ☐ ____ HIV/AIDs
- ☐ ____ Drug/Alcohol Use
- ☐ ____ Genetic Testing
- ☐ ____ Mental Health/Developmental Disabilities

(Office notes, procedures, images, and test results only)