Request of Medical Information

1. **Authorization**: I authorize disclosure of medical information and health records as described below:

   Name of Patient: _____ Date of Birth: _____

   Patient Complete Address: _____

   Social Security Number: ___ - ___ - ____ (Optional) Telephone Number: _____

2. **Record Holder**: _____Circle City Gastroenterology_____

Practice Locations

2250 S. Main St., Ste 201, Corona, CA 92882, TN: 951-808-6298, Fax: 951-523-7065
6900 Brockton Ave., Ste 100, Riverside, CA 92506, TN: 951-808-6298, Fax: 951-523-7065

3. **Records May Be Released To**: _____
   (Hospital, Medical Group, or other Service Provider)

_____
Street Address City State Zip

_____
Telephone Fax

4. **Type of Information**: This authorization is limited to the following type(s) of information indicated below. **Please initial all that apply**

_____ Discharge Summary
_____ Progress Notes
_____ Doctor's Orders
_____ History/Physical Exam
_____Consultation Reports
_____ Emergency Department Reports
_____ Treatment for Alcohol and/or Drug Abuse
_____ HIV Test Results
_____ Psychiatric Records
_____ Billing Information
_____ Radiology/Nuclear Medicine Reports
_____ Operative/Procedure Reports
_____ Any & All Records
_____ Other (Please Specify): _____

5. **Dates of Service**: _____
   From (mmddyyyy) To (mmddyyyy)

6. **Use of Information**: The individual or entity identified above is permitted to use my information for the follow purposes. **Please initial all that apply**.

_____ Transfer of Care _____ Second Opinion _____ Personal _____ Insurance

_____ Legal _____ Continuing of Care _____ Other (Please Specify) _____

7. **Duration**: This authorization is valid for one year from the date next to my signature, unless otherwise noted here: _____

8. **Additional Copy**: I further understand that I have a right to receive a copy of this authorization upon my request.

9. **Redisclosure**: I understand that once received, my records will be subject to re-disclosure and my no longer be protected by federal privacy laws.

10. **Revocation**: This authorization is also subject to written revocation by the Undersigned at any time between now and the disclosure of information by the disclosing party. Written revocation will be effective upon receipt but will not be effective to the extent that the Requester is specifically required or permitted by law.

11. **Explanation**: I understand that my treatment is no way conditioned on whether I sign the authorization and that I may refuse to sign it.

12. **Signature**

Patient Name: _____ Patient Date of Birth: _____

Patient Signature or Authorized Representative: _____

(If Authorized Representative) Name & Relationship to Patient: _____

Date Signed: _____

Witness Signature: _____ Date/Time: _____

Note: Legal documentation along with a current government issued identification (drivers license, identification card or passport) must be provided to prove authority to sign on the patient's behalf.