

CIRCLE CITY GASTROENTEROLOGY

2250 South Main Street, Suite 201, Corona, CA 92882 • (951) 808-6298 • CircleCityGi.com

Request of Medical Information

Authorization

Patient Name: _____ Patient Date of Birth: _____

Patient Address: _____

Patient last 4 digits of Social Security: _____ Patient Telephone Number: _____

Record Holder

Hospital, Medical Group, Physician Name: _____

Hospital, Medical Group, Physician Telephone Number: _____

Hospital, Medical Group, Physician Fax Number: _____

Records May Be Released To:

Circle City Gastroenterology

Type of Information

Discharge Summary Emergency Dept Reports Psychiatric Records
 Progress Notes Laboratory Results Billing Information
 Doctor's Orders Any and All Records Radiology/Nuclear Med Reports
 History/Physical Exam Treatment Alcohol/Drug Abuse Operative/Procedure Reports
 Consultation Reports HIV Test Results (Human Immunodeficiency Virus)
 Other (Please Specify) _____

Dates of Service

- From: ___/___/___
- To: ___/___/___

Use of Information

The individual or entity identified above is permitted to use my information for the following purposes:
(Please initial all that apply)

Transfer of Care Second Opinion Personal Insurance Legal
 Continuing Care Other (Please Specify) _____

Duration

- This authorization is valid for one year from the date next to my signature, unless otherwise noted here:
 ___/___/___

Additional Copy

- I further understand that I have a right to receive a copy of this authorization upon my request.

Redisclosure

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

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.

Explanation

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

Signature

Patient Name Printed: _____ Patient Date of Birth: _____

Patient Signature: _____ Date Signed: _____

If signed by someone other than the patient, indicate relationship to patient: _____

Witness Signature: _____ Date/Time: _____

- ❖ Legal documentation along with a valid ID must be provided to prove authority to sign on the patient's behalf