GASTROENTEROLOGY GROUP OF ROCHESTER, LLP

Consent For Release of Medical Information

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Name: _____, date of birth: _____ Last for digits of SS#: _____
(Print Name)

I do hereby consent and authorize Gastroenterology Group of Rochester, LLP to:

☐ **SEND** my medical records **TO**: ☐ **OBTAIN** my medical records **FROM**:

Name of Facility: _____

Address and Telephone #: _____

The purpose of this release is: (check all that apply)

☐ Moving ☐ Insurance Purpose ☐ Second Opinion ☐ Transferring Care ☐ Personal Review

☐ Other (please specify): _____

A description of Protected Health Information (PHI) to be released: (please check one)

☐ I consent to the release of **all medical records** including records, reports or tests concerning alcoholism and/or drug abuse or treatment information, sexually transmitted disease related and/or psychological or psychiatric treatment. I also understand that the release of information related to the diagnosis or treatment of HIV requires an additional authorization. (This excludes any records transferred to Gastroenterology Group of Rochester, LLP from previous care providers).

☐ I consent to the release of **all medical records** with the following exceptions: *If you want to limit any records previously mentioned in any way, indicate exactly what you do not want released.*

_____

_____

☐ I consent only to the release of **all medical records** pertaining to the following treatment/condition:

_____

_____

☐ I consent to the release of **all medical records** from _____ to _____.
(Date) (Date)

NOTICE TO PATIENT: you may cancel this authorization in writing at any time, except where the release of PHI has already occurred. This authorization will expire one year from the date of consent. **For permanent records transfer, there is a fee of $.75 per page for administrative and copying costs. This fee will not exceed $20.00.**

_____

Signature of Patient, Representative or Legal Guardian Date

_____

Signature of Patient, Representative or Legal Guardian Date

Please mail to: 2080 Clinton Avenue South, Rochester, NY 14618 or fax to: (585) 271-0375

NOTICE TO RECIPIENT OF RECORDS: This information has been disclosed to you from confidential records that are protected by law. State law prohibits you from making any future disclosures of this information without specific written authorization of the person to whom it pertains, or as otherwise permitted by Federal or State law.