giCARE FOR KIDS

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Authorization for Release of Medical Information

Patient's Legal Name: _____
Address: _____
City/State/Zip Code: _____
Date of Birth: _____ Phone number: _____
Date of Request: _____ Date Needed: _____

O I authorize GI Care for Kids- Dr. _____ to obtain FROM OTHER DOCTORS, HOSPITALS, ETC:	O I authorize GI Care for Kids to release information to PARENTS, OTHER DOCTORS, ETC:
Name of Provider or Facility	Name of Provider or Facility
Address	Address
City, State, Zip Code	City, State, Zip Code
Phone # (include area code)	Phone # (include area code)
Fax # (include area code)	Fax # (include area code)

PURPOSE FOR THIS REQUEST: O Healthcare O Insurance Coverage O Personal O Transfer of Care O Other

TYPE OF RECORDS REQUESTED: (check one)

O Copy of entire medical records

O Treatment summary (includes history/ physical, laboratory tests & x-rays reports, operative reports, pathology)

O Specific information (Select one or more, as applicable)

O Procedure Report O History & physical O Laboratory test results O X-ray reports

O Other _____

I understand that:

- My right to healthcare treatment is not conditioned on this authorization
- If the person or facility receiving this information is not a healthcare or medical insurance provider covered by privacy regulations, the information stated above can be disclosed.
- There will be a charge for the requested records. Doctors' offices will not be charged for requested records.
- Please allow 7-10 business days of this request for records to be available for pick-up or delivery

Signature of Patient or Representative: _____

Relationship to Patient (if requester is not the patient): _____

PLEASE FAX BACK TO (404) 503-2249