Raymond M. Thomas, MD, PC – **Gastroenterology/Hepatology**

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient name: _____ Date of Birth: _____

I authorize that my medical records be released **FROM Dr. Raymond M. Thomas** and

be sent TO: _____ _____
Name of physician or person Phone number of physician or person

_____ _____
Address to send the records to Fax number of physician or person

_____
City/State/Zip

Purpose of this request: _____Referral/consultation _____ Personal _____Insurance coverage
l _____Changing physician _____ Other: _____

Type of information to be released:

_____**General Medical records** – (excludes protected records) limited to two years of information including labs and xrays unless otherwise requested.

_____**Specific information only**:

_____ Office notes for date(s) of: _____

_____Procedure report for date(s) of: _____

_____Other: _____

Protected Records or Sensitive Information under law cannot be released without specific authorizations required by State/Federal law. By initialing and completing this section, I authorize the release of the following protected or sensitive information:

_____Drug & alcohol diagnosis/treatment _____Mental health treatment _____AIDS/HIV test results including high-risk behavior

Authorization Valid for (check one):

_____ This request only.

_____ One year from date of this authorization and applies to records of treatment received on or before the date of this authorization.

_____ This request, and for records of any future treatment of the type described above until date of: _____

I understand that: 1) my right to healthcare treatment is not conditioned by this authorization; 2) I may cancel this authorization at any time by submitting a written request, except where disclosure has already been made in reliance on my prior authorization; and 3) there may be a charge for the requested records.

Patient signature: _____ **Date:** _____