Raymond M. Thomas, MD, PC – Gastroenterology/Hepatology
199 Parrish St., Canandaigua, NY 14424
Phone: (585) 394-2520 - Fax: (585) 394-2524

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient name: ____________________________________ Date of Birth: __________________

I authorize that my medical records be **released FROM:**

____ ____________________ ____________________
Name of physician Phone number Fax number

____
Address (include city/state/zip

And sent TO: RAYMOND M. THOMAS, MD, PC, Gastroenterology/Hepatology,
199 Parrish Street, Canandaigua, NY 14424 or Fax to: (585) 394-2524

Purpose of this request: ______Referral/consultation _____Insurance coverage ______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 – applying to the 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 this date: __________

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:** ______________________