Center for Digestive Diseases and Cary Endoscopy Center 112 S.E. Cary Parkway Suite 204 Cary, NC 27518 Phone (919) 854-0041 Fax (919) 854-0049



MEDICAL RECORD REQUEST FORM

PLEASE PRINT

(Patient's Full Name)	(Date	(Date of Birth mm/dd/yy)		(Social Security Number)
(Street Address)	(Cit	(City, State, and Zip Code)		(Phone Number)
At the request of the individual, I do he				do hereby authorize:
(Name o	f Facility and/or S	and/or Specific Provider)		(Fax Number)
(Street addre	reet address, City, State, Zip Code) (Phone Numbe			er of Physician Office)
All Records History and Physica Progress Notes Operative Notes	Pat al Col Rac		atory Reports doscopy Reports	Emergency Reports Discharge Summary Other:
I DO I DO NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment and treatment for alcohol and/or abuse.				
Information Released to: Center for Digestive Diseases and Cary Endoscopy Center 112 S.E. Cary Parkway Suite 204 Cary, NC 27518 Phone (919) 854-0041 Fax (919) 854-0049				
Purpose of Disclosure (circle a Change of doctor Legal	ll that apply): Investigation	Referral Disability De	Insurance	Worker's Compensation Permanent Transfer to another GI
I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for twelve (12) months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person, class of persons, or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized or furnished may not condition its treatment of me on whether or not I sign the authorization.				
Signature of individual, guardi	an, or personal re	epresentative of	of patient's estate	Date