East Valley Gastroenterology & Hepatology Associates

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AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name:_____ **DOB:**_____

I authorize the release of my medical records from/to: _____

To / From: **EVGHA**
600 S Dobson Rd Ste. A1
Chandler, AZ 85224
FAX: 480-786-6996

To / From:
Practice/ Self: _____
Address: _____
Phone/Fax _____

Description of information that may be released:

- □ Complete Medical Record
- □ Lab / Radiology Reports
- □ Operative / Procedure Reports
- □ Hospital Records
- □ Pathology Reports
- □ Other: _____

Date(s) of service:

From:_____ **To:**_____

I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.
This authorization will be valid for one year from date signed unless this office is notified in writing that this authorization to release/obtain health information is revoked by patient.

Medical Records Request Fees for Personal Use:

- I understand that you may charge me a fee of up to $ 15.00 if I request my entire chart for personal use.
- I understand that you may charge me a fee of up to $25.00 if my requested chart exceeds 100 Pages.
- I understand there is no fees for records that are requested for the purpose of continuation of care to a designated Physician or insurance company.
- We are required by law to respond to this request within 30 days of receipt of the request

X _____ _____

Patient or Legal Representative Signature Date