GASTROENTEROLOGY

James E. Cremins, MD | Robinwood Medical Campus | 11110 Medical Campus Road, Suite 242 | Hagerstown, MD 21742

AUTHORIZATION FOR RELEASE OF PATIENT IDENTIFIABLE HEALTH INFORMATION

Date of request _____

I _____ hereby authorize Gastroenterology Solutions to receive

from Digestive Disorders
246 Robinwood Medical Center

The following health information from the medical records of:

_____ _____ _____

Patient's Name | Date of Birth | Soc Security Number

Specified information to be disclosed:

Date of service: _____
last office note
last procedure note

✓ Progress Note ____ History&Physical

____ Lab results ____ Radiology Results

✓ Pathology Results ____ EKG/ECG/EEG Results

Health information is needed for:

____ Personal Use ✓ Continuing Medical Care ____ Relocation/Move

____ Leaving Practice ____ Legal Reasons ____ Insurance ____ Referral to Specialist

Other: _____

I hearby authorize discloser of the health information for the above named patient. This authorization is valid for 12 months for the date of signature. I understand that I may cancel this request with written notification of cancellation. I understand that the information used or disclosed may be subject to re-dicloser by the person or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ _____

Signature of patient, Parent, Guardian, Executor/ Legal Representative | Date

_____ _____

Witness | Date