Gastroenterology Consultants of South Texas

Medical Records Request Form

Patient's Name: _____ Date of Birth: _____

I hereby authorize Gastroenterology Consultants of South Texas, PLLC to request medical records, including AIDSIHIV test results, diagnosis, treatment and related information from:

Doctor/Facility Name: _____

Fax: _____ Phone: _____

Medical Information to be disclosed and or photocopied include:

- ☐ History & Physical
- ☐ Diagnostic Results
- ☐ Discharge Summary
- ☐ Consultations
- ☐ Laboratory & Radiology Results
- ☐ All Dictation
- ☐ Other: _____

1. If my records are protected under the Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, the records cannot be disclosed without my written consent unless otherwise provided for in the regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. Federal rules restrict ant use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
2. With respect to any mental health information which may be contained in the medical records, I hereby waive my/his/her right to the privilages of confidentiality.
3. I also understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it.

The reasons or purposes for this release of information are as follows: **Continuity of Medical Care.**

Limitations on the information you may release subject to this Release Form are as follows:

_____

_____ _____

Patient Signature (Parent/Guardian/Legal Representative) Date