FGA | FREDERICK GASTROENTEROLOGY ASSOCIATES

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

Patient's Name:_____ Date of Birth:_____
(Please Print)_

Address:_____ Telephone No:_____
Street City State Zip code

I hereby authorize: **Frederick Gastroenterology Associates**
7109 Guilford Dr. Suite 300
Frederick, MD 21704
(301) 695-6800 Telephone (301) 695-6891 Facsimile

To Obtain From:

_____
Person/Organization to receive/send information

_____ Telephone Number:_____
Street Name and Number

_____ Fax Number:_____
City State Zip Code

Information to be released:

☐ Recent Office Visit Notes ☐ All Procedure Reports ☐ Recent Laboratory Reports
☐ G.I. Radiology Reports ☐ All Pathology Report ☐ Other_____

I understand that the medical records to be released may contain information related to Hepatitis, HIV status, AIDS, Sexually Transmitted Diseases, Alcohol or Drug use, or Mental Health Services; and hereby authorize the release of this information. All information released will be handled confidentially. This authorization for disclosure is specific for this request only and is valid for one year from the date of release. ***This authorization may be withdrawn by me at any time except to the extent that action has been taken in response thereon.***

_____ _____ _____ _____ ___ _____
Signature of Patient Date Signed Date of Birth Social Security No.

_____ _____
Signature of Parent/Guardian Relationship

Revised 4/16/24