CARMICHAEL OFFICE
6555 Coyle Ave, Ste 330
Carmichael, CA 95608
Phone: (916) 965-9650
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CapitolGI
Capitol Gastroenterology Consultants Medical Group

ROSEVILLE OFFICE
4 Medical Plaza, Ste 205
Roseville, CA 95661
Phone: (916) 773-6200
Fax: (916) 782-4550

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Patient Name: _____

Address: _____

Date of Birth: _____ Telephone: _____

I authorize the release of my medical records from:

Physician/Facility: _____

Address: _____

Telephone: _____ Fax: _____

Please send my medical records to:

Physician/Facility: _____

Address: _____

Telephone: _____ Fax: _____

Reason for release of information:

☐ Insurance ☐ Specialist consult ☐ Personal file ☐ Legal
☐ Moving out of area ☐ Transfer of care ☐ Other: _____

Please release the following records (check all that apply):

☐ All records from last 2 years of treatment ☐ Clinic notes (dates)
☐ Lab/Pathology reports (specify) ☐ Radiology/Imaging reports (specify)
☐ X-Ray films (charge for copies) ☐ TB test results
☐ Immunizations ☐ Other: _____

Consent: This information is intended for use by the above named recipient only. I am aware that the records released may contain information relating to psychiatric or psychological testing, physical abuse, or drug and alcohol abuse. This authorization will expire exactly one year from the date below or on _____. I have the right to receive a copy of this authorization. I may revoke this authorization at any time in writing. I understand that information used or disclosed under this authorization may be subject to re-disclosure by the recipient without being further protected under the HIPAA rules. I understand that I may be charged for copies provided. Incomplete information may cause a delay.

Patient Signature: _____ Date: _____