DHP DIGESTIVE HEALTH PARTNERS
Independent Gastroenterology Specialists

Asheville Gastroenterology Associates
Endoscopy Center of North Carolina
Carolina Mountain Gastroenterology Associates
Carolina Mountain Gastroenterology Endoscopy Center

Authorization to Release Medical Records

Patient Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Phone Number: _____

I hereby authorize:

☐ Carolina Mountain Gastroenterology
☐ Carolina Mountain Gastroenterology Endoscopy Center
☐ Asheville Gastroenterology Associates
☐ Endoscopy Center of North Carolina

☐**To Release** ☐**To Obtain**

My medical records to/from:

Provider/Organization Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Purpose of Release (check all that apply):

☐ Continuation of care
☐ Personal use
☐ Legal matter
☐ Insurance
☐ Other: _____

Information to be released (check all that apply):

☐ Complete medical record
☐ Office visit notes
☐ Lab results
☐ Radiology reports/images
☐ Billing records
☐ Other: _____

Date range of records to be released: From: _____ To: _____

I understand that this authorization will expire on (provide date or specify "no expiration"): _____

Copy fee may be charged for medical records

By signing below, you acknowledge that your records will be shared according to the parameters above:

Responsible Party Name: _____ Today's Date: _____

Responsible Party Signature: _____ Relationship to Patient: _____

You may revoke this authorization at any time by submitting a written request to the medical practice, except to the extent that the action has already been taken based on this authorization.

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