Center for Digestive Diseases
& Cary Endoscopy Center ™

MEDICAL RECORD REQUEST FORM *PLEASE PRINT*

_____ _____ _____

(Patient's Full Name) (Date of Birth mm/dd/yy) (Social Security Number)

_____ _____ _____

(Street Address) (City, State, and Zip Code) (Phone Number)

At the request of the individual, I _____ do hereby authorize:

Center for Digestive Diseases
1120 S.E. Cary Parkway Suite 204, Cary, NC 27518
Phone (919) 854-0041 Fax (919) 854-0049

To release the following:

__ All Records __ Pathology/Laboratory Reports __ Emergency Reports __ ECG/EEG/Cardio Cath
__ History and Physical __ Colonoscopy/Endoscopy Reports __ Discharge Summary __ Progress Notes
__ Radiology Reports __ Operative Notes: __ Operative Notes

__ I DO __ I DO NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome), HIV (Human immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment and treatment for alcohol and/or abuse.

Information Released to: _____

(Name of Facility and/or Specific Provider) (Fax Number)

_____

(Street address, City, State, Zip Code) (Phone Number of Physician Office)

Purpose of Disclosure (circle all that apply): Referral Insurance Worker's Compensation
Change of doctor Legal Investigation Disability Determination Permanent Transfer to another GI

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for twelve (12) months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person, class of persons, or facility receiving it, and would then no longer be protected by federal regulations.
I understand that the medical provider to whom this is authorized or furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ _____

Signature of individual, guardian, or personal representative of patient's estate Date

Per NC General Statues, the Center for Digestive Diseases and Cary Endoscopy Center assesses fees for the resources involved with searching, handling, copying, and mailing of medical records to either the patient, designated representative, or external office. The cost for medical records is as follows:

¢75 per page for the first 25 pages, ¢50 for pages 26-100, and ¢25 for 101+ pages. A min fee of $10 is assessed.

Total pages ____ Cost (1-25) ____ (26-100) ____ (101+) ____ Minimum fee $10 **Total cost for records _____**

THIS SECTION FILLED OUT BY CENTER FOR DIGESTIVE DISEASES STAFF