Monterey Bay GI Consultants Medical Group, Inc.
Monterey Bay Endoscopy Center LLC
23 Upper Ragsdale Drive, Monterey, CA 93940
601 E. Romie Lane, Suite # 1, Salinas, CA 93901
831-375-3577 Phone 831-375-1478 Fax

MEDICAL RECORD RELEASE AUTHORIZATION

Patient's Name: _____ **Date of Birth:** _____ **SS#:** _____

Address: _____ **Home/Cell Phone:** _____

Email Address: _____

A) I hereby authorize records FROM:	**B) To be released TO:**
Name: _____	Name: _____
Address: _____	Address: _____
City/State/Zip: _____	City/State/Zip: _____
Phone #: _____	Phone #: _____
Fax #: _____	Fax #: _____

(Please provide the doctors full name, address, phone and fax number in order for us to obtain/release your records)

C) For Purpose of:

____ Litigation
____ Insurance
____ Self/Personal Copy
____ Another Opinion
____ Disability
____ Work Comp
____ Transfer or Records
____ Other

Record Request Date Range:

_____to _____

____ Physician Office Notes (Last 3 visits ONLY)
____ Operative/Procedure Reports
____ Pathology Reports
____ Laboratory/Stool Results (Last 2 months ONLY)
____ Imaging Reports (No Film)
____ Other _____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____
(Date) (Signature of Patient/Parent/Guardian or Authorized Representative)

This authorization will expire one year from the above date unless I specify an expiration date: _____
(Expiration date of Authorization)

PLEASE READ Fee Information: There is a $15.00 charge for all patient copies.