Gastrointestinal Associates of Cleveland, PC
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Patient's name_____ Date of Birth_____ SS#_____

Release of Information From GAC	Release of Information to GAC
☐ I authorize GAC to release copies of my records as listed below. The information should be sent to: Name of Physician, Institution, self, etc. _____ Address _____ City, State, Zip _____ Telephone Number Fax Number _____ _____	☐ I authorize the release of copies of my records as listed below to GAC. The information should be requested from: Name of Physician, Institution, self, etc. _____ Address _____ City, State, Zip _____ Telephone Number Fax Number _____ _____

Please note that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by GAC.

Dates of Treatment (Which dates of treatment do you need records for?)
Dates: _____
_____
The information that is released should be detailed to specific dates of service, treatment, etc. A meaningful description of the information to be disclosed should be provided.

Information to be released	Reason for disclosure
❑ All records, including other treating physicians ❑ Only GAC records ❑ Lab ❑ X-ray	❑ Continuation of Care ❑ Billing ❑ Other (Please Specify Below) _____

Expiration or revocation of authorization – I understand unless I revoke this authorization at an earlier specified date, it will expire 12 months after the date below.

_____
Signature of Patient or Appropriate Legal Representative Date
(If a personal representative of the individual signs the authorization, a description of such representative's authority to act on behalf of the individual must be provided)

_____
Relationship if not patient
Photo ID was provided_____ yes _____no. If no, the form of patient identification must be so stated, and a copy provided with the authorization. In order to be valid, the signature on the authorization must be after the date of service that is being requested for release.

_____ _____
Witness Date