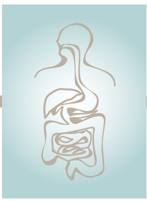

ALISTER A. GEORGE, M.D.
GASTROENTEROLOGY & HEPATOLOGY

Board Certified in Gastroenterology

MEDICAL RECORDS REQUEST AND RELEASE

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information.

Failure to provide all information requested may invalidate this Authorization.

I hereby authorize the use or disclosure of my health information as follows:

____

(Patient Last Name) *(First Name)* *(Initial)* *(Date of Birth)*

____

(Street Address) *(City)* *(State)* *(Zip)*

I authorize ____

(Hospital or Physician)

____

(Street Address) *(City)* *(State)* *(Zip)*

shall provide a summary or copy of my medical records to:

Alister A. George, MD

3510 N. Moorpark Road, Suite 201, Thousand Oaks, CA 91360

Phone (805) 492-4800 Fax (805) 492-4880

for purposes of medical evaluation and treatment. This Authorization applies to the following information as specified below (select only one of the following):

A. ❒ All health information pertaining to any medical history or physical condition and treatment received.
[Optional] Except:____

❒ Only the following records or types of health information (including any dates):

____

B. I specifically authorize release of the following information (check as appropriate):

❒ Medical Procedures and Tests
❒ Lab test results and X-ray reports

This Authorization expires (not to exceed 24 months): _____________________________

(Insert Date or Event)

- I may refuse to sign this Authorization.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the following address:
- My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.
- I have a right to receive a copy of this authorization.
- Neither **treatment**, **payment**, **enrollment nor eligibility** for benefits will be conditioned on my providing or refusing to provide this authorization.
- Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health
information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.
- I may inspect or obtain a copy of the health information that I am being asked to use or disclose.

Signature:__________________________________Date______________Time__________

(Patient / Representative / Spouse / Financially Responsible Party)

If signed by someone other than the patient, state your legal relationship to the patient:_______________________