

Lebanon Digestive Disease Associates, PLC
100 Physicians Way Suite 330
Lebanon TN 37090
(615) 449-6222

RELEASE OF MEDICAL RECORDS

PATIENT NAME:

Patient DOB: _____ **Patient SS#** _____

The above mentioned patient was treated in your facility. We would appreciate your sending a resume of the clinical findings, treatments and copies of any surgical procedure notes and radiology reports. Please also indicate any pathology and / or laboratory results.

- | | |
|---|--|
| <input type="checkbox"/> Colonoscopy Report | <input type="checkbox"/> Pathology Report |
| <input type="checkbox"/> EGD Report | <input type="checkbox"/> Laboratory Report |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> Radiology Reports |

PATIENT AUTHORIZATION:

I hereby authorize:

Name: _____ to furnish Name: _____

Address: _____ 100 Physicians Way Suite 330
Lebanon, TN 37090

Fax: _____ Fax: 615-453-1893

Phone: _____ Phone: 615-449-6222

The healthcare provider must complete the following:

1. What is the purpose of this disclosure? Medical records review for the purpose of consultation.
2. Will the healthcare provider requesting the authorization receive financial compensation of any kind in exchange for using or disclosing the health information described above? NO

The patient or patient's representative must read and initial the following:

1. I understand that my healthcare and the payment for my health care will not be affected if I do not sign this form. Initials _____
2. I understand that I may see and may receive a copy of the information described on this form if I asked for it and that I will receive a copy of this form after I sign it. Initials _____
3. I understand and agree that this authorizes the release of information concerning HIV testing

of AIDS, AIDS-related conditions, drug or alcohol abuse, drug-related conditions, alcoholism and / or psychiatric or psychological conditions. _____

Must be completed for all authorizations:

The patient or the patient's representative must read and initial the following:

1. I understand that this authorization will expire in one year from the date of signature.
Initials _____
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing. Should I do so, this action will not have any affect on any actions taken by the providing organization before they received the revocation.
Initials _____

Signature of Patient or Patient's Representative

Date

Printed Name of Patient or Patient's Representative

01/2008