Fall Hill Gastroenterology Associates
2601 Fall Hill Avenue
Fredericksburg VA 22401
540-371-9696/540-369-6912 fax

Fall Hill Gastroenterology Endoscopy Center
4103 Lafayette Blvd
Fredericksburg VA 22408
540-371-9696/540-369-6912 fax

Authorization to Release Medical Information

Patient Name_____DOB_____

Address_____SSN_____
_____
_____Telephone_____

Physician or Facility where records are being requested FROM:
Physician Name_____
Address_____
_____
Telephone/Fax Number_____
Information requested:
_____All records
_____Labs
_____EKG
_____Office notes
_____Endoscopy report
_____Colonoscopy report

Physician or Facility where records are being sent TO:
Physician Name_____
Address_____
_____
Telephone/Fax Number_____
Information requested:
_____All records
_____Labs
_____EKG
_____Office notes
_____Endoscopy report
_____Colonoscopy report

As the person signing this authorization, I understand that I am giving my permission for FALL HILL GASTROENTEROLOGY ASSOCIATES to send confidential health records to include, if applicable, testing, treatment and/or other information contained in medical records, unless indicated otherwise in the following special instructions:_____

I also understand there will be a $10.00 administrative fee. An additional fee of $0.50 per page up to 50 pages and $0.25 per page thereafter for any records I request which will be payable prior to processing the request. There is no fee, however, for any records requested by another physician.

_____ _____
Signature of Patient or Guardian Date

_____ _____
Witness Date