GAMIT

GASTROENTEROLOGY & ADVANCED METABOLIC INSTITUTE OF TEXAS

# Authorization for Release of Medical Records

## Patient Information

Patient Name: _____ Date of Birth: _____

Phone Number: _____

Address, City, State, Zip Code: _____

_____

I request and authorize _____
(Name of Clinician and Clinic/Practice you want to release your records from)

**To release the medical records of the above-named patient to:**

Name of Recipient: Gastroenterology & Advanced Metabolic Institute of Texas (GAMIT)

Address: 4441 Long Prairie Rd, Suite 100, Flower Mound, TX 75028

Phone: 469-933-2253

Fax: 469-933-2254

## Information to Be Released

[ ] All Medical Records [ ] Office Visit Notes [ ] Lab Results [ ] Imaging Reports

[ ] Procedure Reports. [ ] Other: _____

## Purpose of Release

[ ] Continuation of Care [ ] Personal Use [ ] Insurance [ ] Legal [ ] Other: _____

I hereby authorize the release of my medical records as described below. I understand that this authorization is voluntary and that the information disclosed may be subject to re-disclosure by the recipient.

## Signature

Patient/Guardian Name: _____

Signature: _____

Date: ___ / ___ / _____ Relationship to Patient (if not self): _____