

# GASTROENTEROLOGY & HEPATOLOGY ASSOCIATES, P.C.

SURESH K. MALHOTRA, M.D., F.A.C.P., A.G.A.F.  
RONALD J BARKIN, M.D.  
NISHA CHAND, M.D.

4660 KENMORE AVENUE, SUITE 810  
ALEXANDRIA, VA 22304  
PHONE (703) 823-0333 FAX (703) 823-8611

## AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Street Address, City, State, ZIP: \_\_\_\_\_

Phone Number: \_\_\_\_\_

I, the above named, hereby authorize that my medical records be released FROM

Physician/Organization/Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

\_\_\_\_\_

I, the above named, hereby authorize that my medical records be released TO

Physician/Organization/Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

\_\_\_\_\_

Information to be released

Complete chart \_\_\_\_\_

Other (please specify) \_\_\_\_\_

The purpose of the disclosure of the above information is:

\_\_\_\_\_ Continuing care

\_\_\_\_\_ Permanent transfer

\_\_\_\_\_ Referral

\_\_\_\_\_ Personal use

\_\_\_\_\_ At the request of the party above

\_\_\_\_\_ Other (please specify) \_\_\_\_\_

\_\_\_\_\_ I do or \_\_\_\_\_ I do not consent to the transmission of medical records via facsimile (FAX) machine with the understanding that the confidentiality at the receiving end cannot always be guaranteed.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date