Gastroenterology Associates of Fairfield County P.C.
The Digestive Health Experts

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RECORD RELEASE AUTHORIZATION FORM

I hereby authorize and request Gastroenterology Associates of Fairfield, P.C. to release a copy of my medical record, concerning my illness and/or treatment, as detailed below.

☐ Full medical record held by this office.

☐ Records for the period of ___________________ through ___________________

☐ A specific portion of the record as follows:

____

____

I understand that this request will take at least 48 hours to be processed.

Patient Name: ____ D.O.B.: _____/_____/_____

Address: ____

____

Your Name (if not the patient): ____

Relationship to the Patient: ____

Signature: ____ Date: _____/_____/_____

Records to be sent to:

☐ The patient, information same as above.

Or

☐ Physician or facility as detailed below:

Name: ____

Address: ____

____

Telephone Number: (______) __________-__________ Fax Number: (______) __________-__________.

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