Jay A. Cherner M.D.

A division of

Gastroenterology Consultants P.C.

www.drjaycherner.com

Authorization to Release Medical Records

Patient Name:

Previous Name
(if applicable)

Date of Birth SSN#

PRACTICE or INSTITUTION RELEASING INFORMATION
Name:_____
Address:_____
_____
Phone:_____
Fax:_____

SEND RECORDS TO:
Jay A. Cherner, M.D.
Gastroenterology Consultants, P.C.
3330 Preston Ridge Rd., Suite 220
Alpharetta, GA 30005
Fax: 770-410-0006 Phone: 770-410-1600

Specific Description of Information – indicate treatment dates for each requested item

☐ Office Notes	From ____	To _____	☐ Radiology Reports	From _____	To _____
☐ Lab Reports	From ____	To _____	☐ Pathology Reports	From _____	To _____
☐ Procedure Reports	From ____	To _____	☐ Entire Record – all documents listed above without exception		

The information described above will be used or disclosed for the following purpose(s):

☐Continuity of care	☐Moving	☐Transfer of care	☐Disability determination
☐Insurance	☐Patient's copy	☐Attorney request	☐Other_____

To be completed by the patient or personal representative:

I hereby authorize the use or disclosure of my protected health information as described above. I understand that this authorization is voluntary. I understand that the ability to obtain treatment will not be affected if I do not sign this form, unless that treatment is for a fitness-for-duty evaluation or a records-related treatment. I understand that if the organization authorized to receive the information is not required to comply with the federal privacy protection regulations then such information may be re-disclosed and will no longer be protected. I understand that I have a right to revoke this authorization by sending written notification to: Gastroenterology Consultants P.C., 3330 Preston Ridge Rd., Suite 220, Alpharetta, Georgia 30005. Any revocation will not affect disclosures made prior to Gastroenterology Consultants P.C. receipt of knowledge of the revocation.

I understand that I have a right to inspect and receive a copy of the information described on this form. I certify that I have received a copy of this authorization.

Signature of patient or patient's rep	Printed name of patient's representative	Relationship to patient

Date: _____

Expiration date of authorization: _____ (unless otherwise noted, this authorization will expire 12 months from the date of signature)