REQUEST FOR COPY OF MEDICAL RECORDS

DROP OFF	OR MAIL	OR FAX
The completed form to your provider's office where you received care.	The completed form to our office: 1374 Whitehorse Hamilton Sq Rd 2nd Floor Hamilton, NJ 08690	The completed request to: (609) 586-1468

A copy fee of $1.00 per page, not to exceed $100.00, for patient- requested complete medical chart is required. Should you have any questions, please leave a message at (609) 586-1319 x 156, and we will return your call within 2 business days.

PATIENT Last Name____________________________ **First** ___________________________ **DOB** __________________

ADDRESS: ____

City _______________________________ _________________ **State** ________________________ **Zip** _______________

Home Phone: ____ **Cell Phone:** _____________________________________

Physician Name: DR. AFRIDI DR. ZAMIR DR. MARULENDRA DR. BAIG DR. FAYYAZ DR. BOUCARD

For the following dates of service: FROM: ____________________________ **TO:** _________________________

INFORMATION TO BE DISCLOSED:
- Complete Record
- Labs, X-rays & Tests
- Procedures
- Other: ____

I hereby authorize Hamilton Gastroenterology Group to disclose my health information to:

Name/Company: ____

- *Fax #: __________________________________
- Paper Copies for patient to pick up
  *We do not mail copies of entire medical records to other physician's offices. **FAX ONLY** (*depending on size of chart).*

The information to be disclosed to and used by the above is for the following purpose:

- Personal Use By Patient
- Continuing Care
- Attorney/Legal
- Other: ________________________

see other side

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I understand that the information to be disclosed includes my identity, diagnosis and treatment including ALCOHOL, DRUGS, GENETIC TESTING, and BEHAVIORAL OR MENTAL HEALTH SERVICES, REPRODUCTIVE RIGHTS, SEXUALLY TRANSMITTED DISEASES, AIDS and HIV information, as applicable.

I understand that I have the right to revoke, in writing, this authorization at any time. This authorization will expire ______________________. If I fail to specify an expiration date, it will expire in six months from the date on which it was signed.

I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws.

PATIENT SIGNATURE: ____ **DATE:** _________________________________