DIGESTIVE HEALTHCARE CENTER

Please allow a maximum of 30 days from receipt of request to process and release medical records. Records requests are processed on a first come, first serve basis. If records are needed by a certain date, please specify below:

Need By: _____

P908-218-9222 F908-895-0185

Patient Name	Date of Birth	Telephone
Home Address	City	STATE / Zip Code

I HEREBY REQUEST THAT DIGESTIVE HEALTHCARE CENTER PROVIDE COPIES OF MY MEDICAL RECORDS TO:

☐ MYSELF (patient or representative) ☐ ORGANIZATION/INDIVIDUAL LISTED BELOW:

ORGANIZATION/INDIVIDUAL NAME	PHONE	FAX
STREET ADDRESS	CITY	STATE / ZIP CODE

COVERING PERIODS OF HEALTHCARE FROM _____ TO _____.

RECORDS TO BE RELEASED: **(Note: We can only release records ordered by our physicians)**

- ☐ Office Visit Notes
- ☐ Procedure Notes
- ☐ Pathology Reports
- ☐ Breath Tests
- ☐ **COMPLETE HEALTH RECORDS****
- ☐ Radiology Reports
- ☐ Cat Scan Report Only (Only Cat scans done in our office)
- ☐ Cat scan CDs (Only CT scans done in our office)
- ☐ Laboratory Tests
- ☐ Other _____

****FEES:** THERE IS A $1.00 PER PAGE CHARGE. Fees apply to copies given to patients and their legally authorized representatives only; other fees may apply to other requestors. I accept that Digestive Healthcare Center, PA. is able under state and federal law to charge me a fee for electronic copies or photocopies and any applicable mailing/postage fees for my medical records. The reproduction of records, which shall be no greater than $1.00 per page or $100.00 for the entire record, whichever is less. (If the record requested is less than 10 pages, the licensee may charge up to $10.00 to cover postage and the miscellaneous costs associated with retrieval of the record.) Title 13, Chapter 35. 13:35-6.5(c)4

PURPOSE FOR DISCLOSURE:

- ☐ Changing of Physicians
- ☐ Consultation / Second Opinion
- ☐ Continuing Care
- ☐ Legal
- ☐ School
- ☐ Insurance
- ☐ Worker's Compensation
- ☐ Other:_____

I understand that this will include information relating to (Check if applicable):

- ☐ Acquired Immunodeficiency Syndrome (AIDS)
- ☐ Human Immunodeficiency Virus (HIV)
- ☐ Behavioral Health Service / Psychiatric Care
- ☐ Treatment for alcohol and/or drug abuse

DELIVERY METHOD: (Check one)

- ☐ Mail
- ☐ Fax
- ☐ Publish via patient portal (Patient must be registered with our patient portal to access records)
- ☐ Copy for pick up (Medical Records department will call you when it is ready for pick up)

I understand this authorization may be revoked in writing at any time, except to the extent that the action has taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire in 90 days from the date signed. The facility, its employees and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Patient Signature / Representative: _____

Date: _____