GASTROENTEROLOGY CENTER OF NORTHERN VIRGINIA, LTD.

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REQUEST FOR MEDICAL RECORDS RELEASE to GCNV

Attention (Physician/Facility) _____ Attention _____

Address _____ Phone _____

City/State/Zip _____ Fax _____

Please release medical records for the following patient to Gastro Center of Northern VA.

Patient Name _____ Date of Birth _____

Patient has an appointment or is currently being seen at Gastro Center of Northern VA by:

- ☐ Gabriel B. Herman, MD
- ☐ Pradeep K. Gupta, MD
- ☐ Truc T. Trinh, MD
- ☐ Diego Kuperschmit, MD
- ☐ Rachana Potru, MD

Records are requested for the following time period: _____

Please include:

___ Office Notes ___ Pathology Reports ___ Radiology Reports ___ Procedure Notes

___ Laboratory Reports ___ Entire Chart ___ Specific Test _____

Patient Authorization

I, the undersigned, authorize the release of the medical records indicated above, to be faxed or mailed to Gastroenterology Center of Nothern VA.

___ I do ___ I do NOT authorize release of information related to AIDS (acquired immunodeficiency syndrome) or HIV (Human Immunodeficiency Virus) infections, psychiatric care and/or psychological assessment, treatment for alcohol and/or drug use.

_____ _____

Signature of Patient or Authorized Representative | Date (Authorization will expire six months after date signed)

_____ _____

Print Name of Patient or Authorized Representative | Relationship to Patient

Please fax records to 703-204-1968 or 703-528-4209
If you have any questions, please call our office: 703-522-7476