Jordan & Associates
GASTROENTEROLOGY, P.A.
Christopher P. Jordan, M.D.
Jordan Digestive Diagnostic Center, 649 Guy Road, Clayton, NC 27520
Phone: 919-938-4404 | Fax: 919-938-3055

MEDICAL RECORDS RELEASE

Patient Name: _____

Date of Birth: _____ Patient Social Security Number: _____

☐ Release Records to:

_____
Name

_____
Address, City, State & Zip

(_____)_____ (_____)_____
Phone Number Fax number

☐ Request records from:

_____
Name

_____
Address, City, State & Zip

(_____)_____ (_____)_____
Phone Number Fax number

Information Requested:

☐ **All medical records**: without exception, including progress notes, lab reports, consultations, hospital notes, procedure/operative reports.

☐ **Partial medical records**: Check which records are being requested
☐ Progress notes ☐ lab reports ☐ Consultations ☐ Hospital notes
☐ Procedure/operative report ☐ Other (specify) _____

I hereby authorize the use or disclosure of my protected health information (PHI) as described above. I understand that this authorization is voluntary. I understand that 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 research-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 the right to revoke this authorization by sending written notification to: Jordan Digestive Diagnostic Center, 649 Guy Road, Clayton, NC 27520. Any revocation will not affect disclosures made prior to Johnston & Associates Gastroenterology, P.A.'s receipt or knowledge of the revocation. Unless I revoke this authorization prior to such a time, this authorization shall expire: _____ (90 days if left blank) from the date of my signature. I understand that I have the right to inspect and receive a copy of the information described on this form.

_____ _____
Signature of patient or patient's authorized representative Date

_____ _____
Printed name of patient's representative (if applicable) Relationship to patient

_____ _____
FOR JAG USE ONLY (Faxed By and Sign) Date Revised 9/17