CAROLINA GASTROENTEROLOGY

570 New Waverly Place
Suite 140 Cary, NC 27518
Telephone: (919) 854-2500
Fax: (919) 854-2510

Records Release

To:

Name: _____

Address: _____

Phone: _____ Fax#: _____

I, _____

DOB: _____ SS#: _____

Hereby request that you release my records to:

Dr. Vinod C. Vallabh, M.D., F.R.C.P.

570 New Waverly Place #140, Cary, NC 27518

phone: 919-854-2500 fax: 919-854-2510

Dates of service to be release: _____

Documents to be released: _____

Date of request: _____

The patient hereby consents to the use or disclosure of his/her individually identifiable health information (protected health information) by Carolina Gastroenterology PA. In order to carry out treatment, payment, or health care operations.

Patient retains the right to revoke this consent. Such revocation must be submitted in writing. The revocation shall be effective except to the extent that the facility has already taken action in reliance on the consent.

_____ *Date* _____

Signature of Patient or Personal Representative

Time _____

_____

Print Name

If Personal Representative, what is your relation to the patient _____