Gordon Medical Associates

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Records Request Form

I, _____, Date of Birth, ____/____/_____, hereby request that **Gordon Medical Associates** please release and provide a copy of the following, for the purpose of providing information that may benefit my treatment. I am aware that I may rescind this permission at any time in writing:

		All	**From**
☐	Complete medical records (all of below)	☐	_____ to _____
or			
☐	Patient progress notes	☐	_____ to _____
☐	Lab tests	☐	_____ to _____
☐	CAT scans, US, MRIs and X-rays	☐	_____ to _____
☐	Medications/supplements		

Specific Authorization: (**initial all that apply**) I acknowledge that data to be released MAY INCLUDE material that is protected by Federal Law and that is applicable to EITHER or ALL of these items. My signature below authorizes releases of all such information.	___ HIV test results ___ Mental health treatment ___ Alcohol/drug treatment

Please send my records to:

Name _____

Address _____

City, State & Zip code _____

Phone _____ **Fax** _____

Send my records via: ☐ Fax (no more than 10 pages) ☐ 1st Class mail

Signature: _____ **Date:** ____/____/_____