FRANKLIN GASTROENTEROLOGY

LOCATION:
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Suite 140
Franklin, TN 37067

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FAX: (615) 771-2801

DIRECT ADDRESS:
aighermitage@directaddress.net

WEBSITE:
www.franklingastroenterology.com

PATIENT NAME: _____
PATIENT DOB: _____

We would appreciate it if you could send the requested clinical findings, treatments and copies of any surgical procedure notes and radiology reports. Please also indicate any pathology and /or laboratory results.

[ ] Colonoscopy Report
[ ] EGD Report
[ ] Operative Report
[ ] Pathology Report
[ ] Laboratory Report
[ ] Radiology Reports
[ ] ALL RECORDS

PATIENT AUTHORIZATION:
I hereby authorize Franklin Gastroenterology to furnish medical records to the practice and/or provider listed below.

Practice/Provider: _____
Address: _____
City, State & Zip: _____
Fax Number: _____
Phone Number: _____

The healthcare provider must complete the following:

1. What is the purpose of this disclosure? _____
2. Will the healthcare provider requesting the authorization receive financial compensation of any kind in exchange for using or disclosing the health information described above? NO

The patient or patient's representative must read and initial the following:

1. I understand that my healthcare and the payment for my health care will not be affected if I do not sign this form. **Initials** _____
2. I understand that I may see and may receive a copy of the information described on this form if I asked for it and that I will receive a copy of this form after I sign it. **Initials** _____
3. I understand and agree that this authorizes the release of information concerning HIV testing or treatment of AIDS, AIDS-related conditions, drug or alcohol abuse, drug -related conditions, alcoholism and / or psychiatric or psychological conditions. **Initials** _____

Must be completed for all authorizations:
The patient or the patient's representative must read and initial the following:

1. I understand that this authorization will expire in one year from the date of signature. **Initials** _____
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing. Should I do so, this action will not have any affect on any actions taken by the providing organization before they received the revocation. **Initials** _____

_____ _____
Signature of Patient or Patient's Representative Date

_____
Printed Name of Patient or Patient's Representative