FRANKLIN GASTROENTEROLOGY

LOCATION:

740 Cool Springs Boulevard

Suite 140

Franklin, TN 37067

PHONE: (615) 771-8786

FAX: (615) 771-2801

DIRECT ADDRESS:

aighermitage@directaddress.net

WEBSITE:

www.franklingastroenterology.com

PATIENT NAME: _____

Patient DOB: _____

The above mentioned patient was treated in your facility. 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	[ ] Pathology Report	[ ] ALL RECORDS
[ ] EGD Report	[ ] Laboratory Report	
[ ] Operative Report	[ ] Radiology Reports	

PATIENT AUTHORIZATION:

I hereby authorize the practice/provider listed below to furnish medical records to Dr. Michael Blanco at Franklin Gastroenterology**. If not faxing, please send medical records to Franklin Gastroenterology, 740 Cool Springs Blvd, Ste 140, Franklin, TN 37067.**

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? Medical records review for the purpose of consultation.
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