



PLEXUS GASTRO PLLC ROJA RAMISETTY

Board Certified in Internal Medicine
& Gastroenterology/Hepatology

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Address: 29201 Telegraph Rd, Southfield, MI 48034

PH: (248) 372-9575 F: (248) 856-1260

Authorization for the Release of Medical Records

Where are the records being released from?

Facility Name:

Provider Name(s):

Address:

City:

State:

Tell us about the patient.

Name:

DOB:

SSN: XXX-XX-

Email:

Address:

City:

State:

Zip:

Phone#:

Fax#:

Where are we sending the records?

Name:

DOB:

SSN: XXX-XX-

Email:

Address:

City:

State:

Zip:

Phone#:

Fax#:

What would you like released? Check all that apply.

- All Records Office/Clinic Notes Operative Reports Psychological/Psychiatric conditions, if any
 Lab/Pathology Results Radiology Reports Immunization Records Substance Abuse, if any
 Last Two Years of Records Dates _____ to _____
 Other _____
-

If you do not want certain portions of your medical records released, please check the categories listed below you would like excluded.

- Substance Abuse, if any AIDS/HIV/STDs, if any Psychological/Psychiatric conditions, if any

Purpose of Disclosure: Why are we sending the records?

- Personal Use Litigation/Legal Insurance Continuation of Care Transfer to New Physician

Delivery Method: How would you like the records sent?

- Email Fax Postage (additional fee applies)

Patient's Signature

I hereby authorize **Plexus Gastro PLLC** and its affiliates to release or disclose to the person(s) or organization listed above, all medical records requested, including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, or HIV infection, *unless otherwise noted*. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification, but that it will not affect any information released prior to the cancellation notice. I understand that the information used or disclosed may be subject to re-disclosure by the recipient listed above and will no longer be protected by federal regulations. I further understand that I can refuse to sign this authorization, and that my healthcare provider may not condition treatment on my signing of this authorization.

Patient's Signature:

Date:

Relationship to patient:
