GI Excellence, Inc.

Gastroenterology Associates

Milan S. Chakrabarty, M.D.
General Gastroenterology

Indraneel Chakrabarty, M.D., M.A.
Advanced & Interventional Gastroenterology

Sandra Del Valle, PA-C
Gastroenterology Physician Assistant

Kathleen Linke, PA-C
Gastroenterology Physician Assistant

Office Fax: (951) 658-6476 · Office Hours: 9 a.m. to 5 p.m, M - F

Two Locations:

HEMET
1003 E. Florida Avenue · Suite 101 · Hemet, CA 92543 · (951) 652-2252

TEMECULA
44274 George Cushman Ct. · Suite 208 · Temecula, CA 92592 · (951) 383-6001
(By appt.)

AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF MEDICAL INFORMATION

I hereby authorize the release and/or disclosure of the medical information as indicated below to the health care provider, entity, or person I have indicated above. **I understand there may be a charge for all records requested.** If so, payment is requested before request can be processed. All areas of this form MUST be completed and signed or we will not process your request.

Release and/or disclose records and information regarding:

_____ _____ _____
Name of Patient (List other names used) Date of Birth Phone Number

( ) I request that my medical records from:
_____
_____
_____
Without complete information, we cannot process
Be mailed to:

☐ Milan S. Chakrabarty, M.D.
1003 E. Florida Avenue, Suite 101
Hemet, CA 92543

☐ Indraneel Chakrabarty, M.D., MA
1003 E. Florida Avenue, Suite 101
Hemet, CA 92543

(If less than 5 pages, please call (951) 652-2252 for a fax number)

( ) I request that my medical records from:
Dr. Milan Chakrabarty / ( ) Dr. Indraneel Chakrabarty release my medical records to:
_____
_____
_____
Without complete information, we cannot process.
If you would like us to call you when your records are ready for pick up, please give us your phone number.

Call me at ( )_____

Address_____ City_____ State_____ Zip_____

PLEASE MARK ONE BOX BELOW:

DURATION: This authorization shall become effective immediately and shall remain in effect until _____(enter date) or for one year from the date of signature if no date is entered.
REVOCATION: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.
REDISCLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.
SPECIFY RECORDS TO BE RELEASED AND/OR DISCLOSED:

☐ General Medical Information (from_____ to_____)
☐ Information Regarding Specific Injury or Treatment (from to)
☐ X-ray (reports only)
☐ Laboratory Results

☐ Mental Health (from _____to_____)
☐ Alcohol/Drug (from _____ to_____)
☐ HIV Test Results (from _____ to_____)

_____ _____
Signature of Patient or Patient's Representative Date

_____ _____
Signature of Patient or Patient's Representative Date

_____ _____
Signature of Patient or Patient's Representative Date

☐ Other (specify):_____

I request that the health information released and or disclosed pursuant to this authorization be used for the following purposes only:
(What is the reason for this request)_____

A copy of this authorization is valid as an original. I have the right to receive a copy of this authorization. The copy is for me to keep.

_____ _____
Signature of Patient or Patient's Representative (Indicate Relationship if signed by other than patient) Date