



Pramod Malik, MD

FACG, FASGE, AGAF, CPI

Board Certified in Gastroenterology

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name in full: _____

Other names (Aliases): _____

Date of Birth: _____

Social Security #: _____

Reason for disclosure: (Check one) Medical care Second opinion Transfer of care Other _____

Entity FROM whom the information is requested:

Physician/ organization: _____

Street Address: _____

City: _____

State: _____

Zip: _____

Tel: _____

Fax: _____

Entity TO whom the information is to be sent to:

Physician/ organization: Pramod Malik, MD – Virginia Gastroenterology

Street Address: 2790 Godwin Blvd; Suite 205

City: Suffolk

State: VA

Zip: 23434

Tel: 757-942-2566

Fax: 855-313-1070

Information requested:

Progress & consult notes (In/Outpt)

Other _____

Endoscopic procedure & Path reports

Operative procedure notes

Lab reports

CT/MRI/MRCP/ US/ radiology procedures

1. I hereby authorize and request release of my above Protected (individually identifiable) Health Information to **Virginia Gastroenterology Institute, PC (VGI)**.
2. I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse, and/or HIV/AIDS test results or diagnoses.
3. I understand that I may revoke this authorization at any time by notifying the releasing organization in writing but it does not affect the information already received by **VGI**. I understand that if the organization authorized to receive the information is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and will no longer be protected.
4. I understand that this authorization is voluntary and that I do not have to sign this authorization. My refusal to sign will not affect my ability to obtain treatment.

Signature of patient or patient's representative

Date

Printed name of patient's representative

Relationship to the patient

(This form MUST be completed before signing)

Form Last Updated: Oct 2018