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: *Pramod Malik, MD-Virginia Gastroenterology*		
Street Address: *3910 Bridge Road, Suite 101*		
City: *Suffolk*	***State:*** *VA*	***Zip:*** *23435*
Tel: *757-942-2566*	***Fax:*** *855-313-1070*	
Entity TO whom the information is to be sent to:		
Physician/ organization:		
Street Address:		
City:	***State:*** *VA*	***Zip:*** *23434*
Tel:	***Fax:***	

Information requested:

___ *Progress & consult notes (In/Outpt)*
___ *Endoscopic procedure & Path reports*
___ *Lab reports*
____ *Other* _____
____ *Operative procedure notes*
____ *CT/MRI/MRCP/ US/ radiology procedures*

1. *I hereby authorize and request release of my above Protected (individually identifiable) Health Information from* ***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*