Medical Records Release Form

Tri-Cities Digestive Health Center, PS Mid-Columbia Endoscopy Center, LLC

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____

Address: _____

Contact Phone: _____

Social Security (Medicare patients only): _____

I, (patient name) _____ hereby authorize (provider/facility) _____

Facility phone: _____ Facility Fax: _____

to release the information specified below from my medical records.

The information requested is to be released to:

Tri-Cities Digestive Health Center, PS and/or Mid-Columbia Endoscopy Center, LLC

8819 W. Victoria Ave., Kennewick, WA 99336

Phone: 509-460-5500 Fax: 509-460-5111

The following information is to be released:

- History & Physical, chart notes
- Labs, EKG, and Radiology reports
- Hospital Records
- All Endoscopy reports: Colonoscopy, EGD, ERCP-including photos, and pathology reports
- Other: _____

I request the above records be faxed no later than: _____

By my signature, I authorize the release of the above medical records. Furthermore, this authorization may be revoked at anytime with the exception of those items that have already been released. I understand that such information cannot be disclosed without my specific written consent, except in a medical emergency.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____