



# GASTROENTEROLOGY Associates, PC

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## Authorization to Obtain Medical Records

I hereby authorize: \_\_\_\_\_  
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To disclose the following protected health information to:

**Gastroenterology Associates, PC**  
Fax (540) 349-4683

**Please send only paper documents. Do not send CDs.**

170 W Shirley Ave, Suite 205, Warrenton, VA 20186; Phone (540) 347-2470

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Date of Records: All Records \_\_\_\_\_  
From: \_\_\_\_\_ To: \_\_\_\_\_

\_\_\_\_\_  
*Signature of Patient or Personal Representative*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Printed Name of Patient or Personal Representative*

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Staff Initials \_\_\_\_\_

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