GASTROINTESTINAL MEDICINE ASSOCIATES, INC.

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PAUL W. RODERICK, M.D., F.A.C.G.
MORRIS P. ELEVADO, M.D.
DEIRDRE E. SMITH, APRN, CNP

THOMAS H. McGREEN, M.D.
ROBERT J. BIERWIRTH, M.D.
JENNIFER L. GEREMIA, PA-C
LAUREN M. GALLAGHER, APRN, CNP

ROBERT WOLFGANG, D.O.
COLIN WOODARD, D.O.
JODI CUSACK, PA-C

I, _____hereby request that my medical records be transferred to:

_____

_____

FROM:_____

_____

_____

FOR THE PURPOSE OF CONTINUED MEDICAL CARE.

PLEASE RELEASE RECORDS OF:

_____

_____

_____

I understand that my medical records may contain confidential information concerning: mental health, alcohol, and/or drug abuse, sexual abuse, venereal disease, hepatitis, aids, or HIV test results.

Patient Signature:_____

Date:_____**D.O.B.**:_____

(THIS MEDICAL RELEASE IS GOOD FOR ONE YEAR FROM THE ABOVE DATE)

Address:_____

Witness:_____

Cranston and East Greenwich FAX: 401-228-7109

Narragansett and Westerly FAX: 401-789-2226

1150 Reservoir Avenue - Suite 201
Cranston, RI 02920
(401) 943-1300

360 Kingstown Road - Suite 202
Narragansett, RI 02882
(401) 789-1860

3461 So. County Trail - Suite 201
E. Greenwich, RI 02818
(401) 943-1300

268 Post Road - Specialty Suite
Westerly, RI 02891
(401) 789-1860