



GASTROINTESTINAL MEDICINE ASSOCIATES, INC.

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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