On page 2 of this document you will find a form that you can use to request the release of your medical records. Please sign and mail the release form to **Sarasota Digestive Health Specialists** at the address below for transfer of your medical records to our new location. Alternatively, you may choose to fax the request form to: **941.894.3494**

SARASOTA DIGESTIVE HEALTH SPECIALISTS

1801 Arlington Street, Suite 101

Sarasota, FL 34239

Tel: 941.894.3490

Fax: 941.894.349

MEDICAL RECORDS REQUEST

I _____ give permission to Gastroenterology Associates of Sarasota to release any and all of my medical records to: **Sarasota Digestive Health Specialists**.

I understand that this record may contain administrative and/or billing information and I give permission for release of that information.

I understand that this record may contain information about HIV test results. I give my permission for release of this information.

I also give my permission for this material to be transmitted by fax to: **941 894 3494.** I understand that faxing records may result in transmission to the wrong number. I accept the risk of mistransmission if my records are faxed and I release the sender of any liability for mistransmission by fax.

Signed _____ Date _____

If not signed by the patient, please complete the following:

I am legally authorized to release medical records for the above named patient because I am the (circle one) parent, guardian, personal representative, other (please describe):_____ of this patient