

OHIO VALLEY COLON & RECTAL SURGEONS, INC.

801 St. Mary's Drive West, Suite 300

Evansville IN 47714-0560

James D. Waller, M.D., F.A.C.S. Deane L. Smith, II, M.D. F.A.C.S.

Syam S. Chilukuri, M.D., F.A.C.S. Santiago Arruffat, M.D.

(812) 477-9241 1-800-371-1169 FAX: (812) 474-6708

**REQUEST FOR RELEASE OF
MEDICAL RECORDS TO OHIO VALLEY
COLON & RECTAL SURGEONS, INC.**

Regarding:

Patient Name Patient Social Security Number Person requesting release

Patient Address (street) Patient Date of Birth

Patient Address (City/State/Zip)

Release records from: _____
Physician/Provider Name

Address

I, the undersigned, authorize you to furnish a copy of or to allow the following medical records to be reviewed:

Records from _____ to _____ All dates _____
Date Date Check for all

Regarding my:

- ___ All medical record information/ or as noted below:
- ___ My diagnosis ___ Hospital/surgery information
- ___ My prognosis ___ Operative reports
- ___ Other (following specific documents) _____

PURPOSE OF RELEASE:

I authorize release to Ohio Valley Colon & Rectal Surgeons, Drs. Waller, Smith, Chilukuri, and Arruffat for the following purpose _____

Any other use is forbidden.

ADDITIONAL RELEASE(Check as applies)

This authorization specifically authorizes Dr. _____ to disclose HIV Test results or diagnosis and AIDS and AIDS-related conditions.

This authorization specifically authorizes Dr. _____ to disclose records of alcohol abuse and substance abuse.

I understand that I may revoke this authorization at any time, except to the extent that the provider listed above has already taken action in reliance on it (e.g., probation, parole, etc.) And that in any event this authorization expires automatically sixty (60) days from date of my signature or as specified by date, event or condition as follows: _____

Signature of patient or authorized person Relationship to patient Date Legal Representative

Witness Signature Date