



Anne Arundel Gastroenterology Associates, P.A.

**Request for Transfer of Medical Records  
to  
Anne Arundel Gastroenterology Associates**

Date: \_\_\_\_\_ Date Records are needed: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Medical Record Number: \_\_\_\_\_

Person Requesting Records: \_\_\_\_\_ Relationship: \_\_\_\_\_

Purpose: \_\_\_\_\_

I request and authorize \_\_\_\_\_  
(Print Physician's/Hospital Name)

to release my medical records to Anne Arundel Gastroenterology Associates for my continued treatment.

All Records \_\_\_\_\_ (Patient's Initials)       Specific Records/Information \_\_\_\_\_ (Patient's Initials)

I give special permission to release any information regarding (check and initial on line(s) below that you wish to grant special permission to release)

Substance Abuse \_\_\_\_\_       Psychiatric/Mental Info. \_\_\_\_\_       HIV Info. \_\_\_\_\_

This authorization will automatically expire upon completion of the request or when withdrawn by the person who authorized the records release, whichever occurs first. I understand that I may withdraw this release request at any time up to the completion of the release.

Please transfer or release my records as indicated above to:

Anne Arundel Gastroenterology Associates, PA

820 Bestgate Road, Suite 2A, Annapolis, MD 21401

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_