Byrd S. Leavell, Jr., M.D.
Michael J. Oblinger, M.D.
Daniel J. Pambianco, M.D.
David H. Balaban, M.D.
Diego A. Gomez, M.D.

Lynn Valentine, FNP
Amy E. McDonnell, FNP
Donna H. Smith, FNP
Catherine Easter, FNP

Charlottesville Gastroenterology Associates
PATIENT REQUEST FOR ACCESS TO HEALTH INFORMATION

Date: ____________ Patient Name: ____

DOB: ____________

Patient Address:
____

____

Patient Telephone: ____

REQUEST:
I hereby request that Charlottesville Gastroenterology Associates provide me with (check all that apply):

___ Access to ___ My own copy of the requested information checked below:

___ Colonoscopy/pathology reports only

___ My complete medical records

___ My billing records

___ Any other personally identifiable information used by CGA to make medical decisions about me. Please describe:
____

____

___ I am interested in acces to o obtaining a copy of all requested information maintained by CGA.

___ I am interested in accessing or obtaining a copy of the requested information relating to the following time period: _______________________________ through ____________________________

___I would prefer to receive the requested information in the form of a summary prepared by CGA at a cost to me of $________________________ (cost will be determined based on complexity of the chart).

___ By requesting these records, I am indicating I am no longer a patient of Charlottesville Gastroenterology Associates.

Reason information is being requested: ____

____

____
Signature of patient

OR

____
Signature of Legal Representative/Relation to Patient