Isaias Irgau M.D., F.A.C.S., F.R.C.S. (Ed), F.A.S.M.B.S
Gail M. Wynn M.D., F.A.C.S
Michael Peters Jr M.D., F.A.C.S., F.A.S.M.B.S.
Rahul Singh M.D.
Sachin Vaid M.D., M.S., M.R.C.S. F.A.C.S, F.A.S.C.R.S
Caitlin Halbert D.O., M.S.

CHRIAS
Christiana institute of Advanced Surgery, P.A.

Bariatric Surgery
Robotic Surgery
Advanced Laparoscopy
Endoscopy
Colorectal Surgery

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Please send a copy of this release with their requested records.

PATIENT INFORMATION (Please Print)

✓ Patient Name		✓ Date of Birth / /		Social Security Number _____ - _____ - _____
✓ Address	City	State	Zip	✓ Phone

RELEASE FROM (Name of Physician or Facility)

I authorize release of my medical records from: **Christiana Institute of Advanced Surgery**

537 STANTON-CHRISTIANA RD, SUITE 102	NEWARK	DE	19713	*Phone* 302-892-9900
Address	*City*	*State*	*Zip*	*Fax* 302-892-9980

RELEASE TO (Name of Physician or Facility Receiving Information)

Please send my medical records to:
Physician / Facility

Address	City	State	Zip	✓ Phone ✓ Fax

RELEASE INFORMATION

✓ Reason:
- ☐ Change of Insurance
- ☐ Moving Out-Of-Area
- ☐ Transfer of Care
- ☐ Specialist Consultation
- ☐ Personal File
- ☐ Legal

✓ Please release the following (check all that apply)

- ☐ Recent H & P
- ☐ Lab Reports
- ☐ Hospital Reports
- ☐ Last Three (3) Visits
- ☐ X-Ray Reports
- ☐ Others:

Please allow 15 days for processing. Incomplete information will delay processing.
Use of this information for any other than the stated purpose is prohibited.
This information is for the use of designated recipient only and cannot be provided to any other agency.

CONSENT

I authorize the release of all information indicated, and I am aware that the records released may contain information relating to psychiatric or psychological testing, physical abuse, or drug and alcohol abuse.

I authorize the release of HIV/HTLV/AIDS test result	☐ YES	☐ NO
I understand that I may be charged for copies provided	☐ YES	☐ NO

✓ _____ ✓ _____
Signature of patient, parent, guardian, conservator, or patient representative (circle one) — Date

✓ _____ _____
Witnessed by: — Date

Note: *This consent is valid for 90 days. It may be revoked by the signer at any time.*

For Office Use:

Released/ Mailed/Faxed:	Received By:
Initial/Date:	Signature/Date: