Portland Gastroenterology CENTER

161 Marginal Way
Portland, Maine 04101
(207) 773-7964 • (207) 773-9073 fax
www.portlandgastro.com

Patient Record Request

Patient Name _____ I.D.# _____ DOB: _____
(please print)

I _____ hereby request the following:
Patient and/or Patient Representative

____ To receive a paper copy of my record

____ To receive an electronic version of my record in the form and format indicated here (**email unavailable**):
_____

Information to be disclosed:

____ Entire medical record

____ Medical record from this date _____ to this date _____

Requests must be submitted in writing to Portland Gastroenterology Associates, PA & Portland Endoscopy Center and if approved, an agreed upon date, time and place will be scheduled. If the electronic form and format requested is not readily producible by Portland Gastroenterology Center in such form and format requested, then Portland Gastroenterology Center will provide a readable electronic form and format as agreed. A nominal fee may be charged for the labor of copying, whether in paper or electronic form, and supplies for creating a paper copy or electronic media if requested on portable media. If the request is denied, the patient and/or patient representative will be informed as to the reason why.

_____
Signature of Patient and/or Patient Representative

_____
Print Patient and/or Patient Representative Name

Date _____