



Gastroenterology
Associates P.C.

Patient's Authorization for Release of Information

Name of Patient: _____

Patient Birthdate: _____ Social Security Number: _____

Release of Information **From:** _____

Release of Information **To:** _____
(name and address) _____

Information to be released: _____ All (including the protected information in the box below. You must indicate this by checking the yes in the box by the corresponding information. If you choose not to have the specific information sent, you must mark no below).

_____ Specific (_____ doctor notes, _____ labs, _____ x-rays)

_____ Other (please indicate): _____

Authorization for release of information protected by law	
Answer all either "Yes" or "No" (there must be a mark by each line)	
YES	NO
_____	_____ AIDS related test results and information
_____	_____ Substance abuse information
_____	_____ Mental Health information

Signature of patient (18 or older) or Legal guardian

Date:

I fully understand that:

- The medical records and/or information that I have authorized to be disclosed hereunder are privileged, confidential and may only be disclosed with my authorization, except as required by law.
- Only such records and/or information reasonably believed necessary are to be released and disclosed.
- Only records and/or information that were a result of tests, labs or procedures that were ordered by my physician at this office are eligible to be sent. Any other records that are part of my chart must be released from the referring physician's office.
- I may inspect and copy the records/information that are to be disclosed prior to sending.
- I understand that this consent is revocable at any time prior to the release of this information. This authorization is only valid for 120 days (OR 6 MONTHS) from the date below.
- If I refuse to sign this authorization, my medical records/information will not be released.