



Gastroenterology Specialists of Oregon, P.C.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient's Name (please print) _____

Address _____ DOB: _____

Day-time Phone Number _____ Evening Phone Number _____

(FROM) I authorize (name) _____

(address) _____

(phone number) _____ (fax number) _____

To disclose the following health information: History & Physical _____ Hospital Notes _____
X-rays/Reports _____ Office Notes _____ Lab, Pathology Reports _____ Operative or Procedure Reports _____
pertaining to (diagnosis) _____ for dates of service _____

Requesting restrictions for the following records: _____

For the following reason(s): Referral/Consult _____ Insurance _____ Legal _____ Self _____ Change of Practitioners _____

(TO) (Practitioner or Facility) _____

Address _____ Fax _____

PLEASE NOTE: If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure may apply. **By initialing the appropriate spaces, I authorize release of this information:**

HIV/AIDS information _____ Mental Health Treatment _____
Drug abuse/Alcoholism Treatment _____ Genetic testing _____

I understand that the information to be used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under Federal law. However, I also understand that Federal or State law may restrict redisclosure of HIV/AIDS, mental health information, genetic testing, and drug or alcohol treatment or referral information. I have the right to revoke this authorization at any time with a written letter to Medical Records.

You do not need to sign this authorization. Refusal to sign will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstances when refusal to sign means you will not receive health care services, is if these services are solely for the purpose of providing health information to someone else and authorization is necessary.

We cannot be responsible for records forwarded to you via Secure Messaging (e-mail) if you use a shared email address.

I have read and understand this authorization. Unless revoked, this authorization will expire in 180 days.

PATIENT SIGNATURE _____

Relationship to patient (if applicable): _____

Date _____

Account # _____