



Gastroenterology  
Associates P.C.

## Patient's Authorization for Release of Information

Name of Patient: \_\_\_\_\_

Patient Birth date: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Release of Information **From:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Release of Information **To:** \_\_\_\_\_  
(Name and address) \_\_\_\_\_  
\_\_\_\_\_

**The use or disclosure (as applicable) is for the purpose:**

Continuing Medical Care       Insurance       Legal  
 SSI Disability Appeal       Research       At the request of the patient  
 Other \_\_\_\_\_

**Information to be released:**

Consultation Reports       History and Physical       Lab(s) Reports  
 Operative/Procedure Reports       Radiology Reports       Pathology Reports  
 Specific \_\_\_\_\_

**Please indicate dates of treatment:** \_\_\_\_\_

**Authorization for release of information protected by law**

You must indicate authorization by initialing "Yes" on each line. If you choose not to have specific information sent, you must initial the "No" line.

AIDS related test results and information       Yes       No  
Substance abuse information       Yes       No  
Mental Health information       Yes       No

**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 is 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 (6 months) from the date below.
- If I refuse to sign this authorization, my medical records/information will not be released.

\_\_\_\_\_  
Signature of patient (18 or older) or Legal guardian

\_\_\_\_\_  
Date