Gastroenterology Associates

Gastroenterology and Hepatology

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: ______________________________ **Date of Birth:** ___________________

Previous Name: ____________________________ **Phone Number:** _________________

I hereby authorize Gastroenterology Associates, Memorial Medical Plaza, 500 Lilly Road N.E., Suite 204, Olympia, WA 98506 to either (**check one**):

- ☐ Request My Health Care Information ***from***:
- ☐ Release My Health Care Information ***to***:

Name/Practice ____

Address ___________________________________ City/State __________________ Zip _______

(Complete address must be provided to process request)

You may use or disclose the following health care information, including drug and/or alcohol history (check all that apply):

- ☐ All health care information in my medical record
- ☐ Health care information in my medical record relating to the following treatment or condition: ____
- ☐ Health care information in my medical record for the date(s): _______________
- ☐ Other (e.g., x-rays, bills), specify date(s): _______________________________

Specifically exclude the following:

☐ HIV/AIDS ☐ Sexually transmitted diseases ☐ Psychiatric disorders/mental health

Reason(s) for this authorization (check all that apply):

- ☐ Health care treatment or transfer of care
- ☐ Personal
- ☐ Other (specify) ____

This authorization ends: (This document does not permit disclosure of health information created more than 90 days after the date it is signed).

- ☐ in 90 days from the date signed ☐ on (date): _______________________
- ☐ when the following event occurs: ____

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment). However, I do have to sign an authorization form:

- To take part in a research study or
- To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Gastroenterology Associates based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available from Gastroenterology Associates. **Or**
- Write a letter to Gastroenterology Associates.

Once health care information is disclosed, the person or organization that receives it may re-disclose it and Privacy laws may no longer protect it.

______________________________ ______________ ________

Patient or legally authorized individual signature | Date | Time

______________________________ ______________________

Printed name if signed on behalf of the patient | Relationship to patient (parent, legal guardian, personal representative)

____

Printed name of patient or patient's representative

____

Relationship to the patient