GASTROENTEROLOGY CONSULTANTS, PC
2860 CREEKSIDE CIRCLE MEDFORD, OR 97504
PHONE: (541)779-8367 FAX: (541) 779-7471

AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

I authorize: ____
(Name of Physician/Medical Facility)
Phone: ____________________________________ Fax: ___________________________________

To disclose a copy of the specific health and medical information described below regarding:

____ ____
(Name of patient) (Date of Birth)

Consisting of: All Records Consult Notes Labs Procedure Notes X-Ray Other (list below)

____
(Describe information to be used/disclosed)

To: **GASTROENTEROLOGY CONSULTANTS PC, 2860 CREEKSIDE CIRCLE, MEDFORD, OR 97504**
FAX (541) 779-7471

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 of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information listed below:

_______ HIV/AIDS information _______ Drug/Alcohol diagnosis, treatment or referral information
_______ Mental Health information _______ Genetic Testing information

You have the right to revoke this Authorization in writing at any time. For more information please refer to our Notice of Privacy Practices.

I have reviewed this Authorization and I understand it. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

SIGNATURE: _______________________________________ DATE: ________________________________
(Patient)
- OR -

BY: ____ DATE: ________________________________
(Patient representative)
Description of Representative's Authority: ____