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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 for **continuation of care**:

Patient Name **Date of Birth**

CONSISTING OF: ALL **GI RELATED** RECORDS, CONSULT NOTES, LABS, PROCEDURE NOTES, XRAY, 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

Minors – a minor patient's signature is required in order to disclose information related to reproductive care, sexually transmitted diseases (if age 14 or older), HIV/AIDS (if age 14 or older), drug and/or alcohol abuse (if age 13 or older), and mental health or illness (if age 13 or older).

Patient Rights - You have the right to revoke this Authorization in writing at any time. For more information please refer to our Notice of Privacy Practices. This release is valid for one (1) year from the date below.

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:_____