



GASTROINTESTINAL & LIVER CONSULTANTS

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ Date of Birth: _____

Phone(H): _____

Address: _____ City/State/Zip: _____

FOR STAFF USE ONLY

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: _____ Facility Phone: _____

Facility Address: _____ Facility Fax: _____

Dates and Type of Information to Disclose:

- 2 years before the last date seen.
- Other Dates: _____
- Radiology (X-rays, US, CT scans, MRIs, etc.)
- Laboratory Results
- Procedure Reports (Colonoscopy, EGD, ERCPs)
- Specific Information Requested: _____

The purpose of disclosure is:

- Change of insurance or physician
- Continuation of care
- Referral
- Other

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RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date of this authorization unless other dates are specified.

I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following organization:

Release to: Gastrointestinal and Liver Consultants Address: 710 N Euclid St #210 Anaheim CA 92801

Fax Number: 657-208-9732 Alternative Fax Number: 657-233-0011

Office Number: 657-900-4536

- Please fax records.
- Please email records.
- Please mail records.

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition:** _____ **If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure, and federal confidentiality rules may not protect the information. If I have questions about the disclosure of my health information, I can contact the authorized organization making the disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Signature of Patient/ Parent/ Guardian or Authorized Representative

Date

Printed Name of Authorized Representative

Relationship / Capacity to patient