

## AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

I authorize Eugene Gastroenterology Consultants, P.C. to release a copy of medical information to:

Name of recipient: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

The information will be used on my behalf for the following purposes(s): \_\_\_\_\_

Please send the records by:

fax     mail     I will pick up at the office     Patient Portal – Secure Message

By initialing the spaces below, I specifically authorize the release of the following medical records, if such records exist:

_____ Most recent two year history	_____ Clinician office chart notes	_____ Diagnostic imaging reports
_____ Operative reports	_____ Laboratory reports	_____ Pathology reports
_____ Please send the entire medical record (all information) to the above named recipient. The recipient understands this record may be voluminous and agrees to pay all reasonable charges associated with providing this record.		
_____ Other _____		

*INITIAL TO CONSENT RELEASE OF THE FOLLOWING:*

_____ Mental health information	_____ HIV/AIDS information	
_____ Genetic testing information	_____ Drug/alcohol diagnosis, treatment or referral information	

\_\_\_\_\_ This authorization is limited to the following treatment: \_\_\_\_\_

\_\_\_\_\_ This authorization is limited to the following time period of treatment: \_\_\_\_\_

\_\_\_\_\_ This authorization is limited to workers' compensation claim for injuries of: \_\_\_\_\_

*This authorization must be written, dated and signed by the patient or by a person authorized by law to give this authorization. This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.*

*We cannot be responsible for records forwarded to you via Secure Messaging (email) if you use a shared email address.*

Patient Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_