



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 Other: _____

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

- | | | |
|--|---|---|
| <input type="checkbox"/> Most recent two year history | <input type="checkbox"/> Clinician office chart notes | <input type="checkbox"/> Diagnostic imaging reports |
| <input type="checkbox"/> Operative reports | <input type="checkbox"/> Laboratory reports | <input type="checkbox"/> Pathology reports |
| <input type="checkbox"/> 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. | | |
| <input type="checkbox"/> Other _____ | | |

INITIAL TO CONSENT RELEASE OF THE FOLLOWING:

- | | | |
|--|--|--|
| <input type="checkbox"/> Mental health information | <input type="checkbox"/> HIV/AIDS information | |
| <input type="checkbox"/> Genetic testing information | <input type="checkbox"/> Drug/alcohol diagnosis, treatment or referral information | |

This authorization is limited to the following treatment: _____

This authorization is limited to the following time period: _____

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.

Patient Name: _____ Date of birth: _____ Phone: _____

Address: _____

Signature: _____ Date: _____