Eugene Gastroenterology
CONSULTANTS, P.C.

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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.

I have reviewed and I understand this Authorization. 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.

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

Address: _____

Signature: _____ Date: _____