**GASTRO HEALTH**
**MIDDLESEX ENDOSCOPY CENTER**
**Authorization To Use and Disclose Protected Health Information**
**For Purposes Other Than**
**Payment, Treatment and Health Care Operations**

Patient Name: _____
Last First Middle
Home Address: _____

Home Telephone: _____ Date of Birth: _____

Specify Information to be Disclosed: _____
_____
_____.

**Recipient**: Name of person or class of persons to whom the Practice may disclose my health information: _____.
Address of the recipient or where my health information should be delivered: _____
_____.
**Term:** This Authorization will remain in effect:
☐ From the date of this Authorization until the 31st day of December 2030.
☐ Until the following event occurs: _____.
☐ Other: _____.

By signing below, I hereby authorize the Practice to use and/or disclose to the recipient my health information for the term of this Authorization for the following specific purpose(s): ("At the request of the patient" is sufficient if the patient is initiating this Authorization):
_____
_____.

I understand that once Gastro Health discloses my health information to the recipient, the Practice cannot guarantee that the recipient will not redisclose my health information to a third party. Any such third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of the Practice's treatment of me; except, however, if my treatment at the Practice is for the sole purpose of creating health information for the disclosure to the recipient identified in this Authorization, in which case the Practice may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to the Practice's Privacy Office at the address listed below. The revocation will be effective immediately upon the Practice's receipt of my written notice, except that the revocation will not have any effect on any action taken by the Practice in reliance on this Authorization before it received my written notice of revocation.

I may contact the Privacy Manager by mail at 45B Discovery Way Acton, MA 01720, and I may contact the Practice Manager by telephone at (978) 429-2010.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly, and voluntarily, authorize the Practice to use and/or disclose my health information in the manner described above.

_____ _____
Signature of Patient Date

If the patient is an unemancipated minor or is otherwise incapacitated (physically or mentally), obtain the following signatures:

_____ _____ _____
Signature of Personal Representative | Description of Authority | Date

**My Highly Confidential Information:**

By signing below, I specifically authorize the use and/or disclosure of the following types of highly confidential information, if any such information will be used or disclosed pursuant to this Authorization:

**[Note to patient: Please strike any of the bullet points listed below, to the extent you do not want the information disclosed by the Practice.]**

- Information about HIV/AIDS status
- Information related to confidential communications with a psychotherapist, psychologist, social worker, sexual assault counselor, domestic violence counselor or other allied mental health professional or human services professional
- Information about treatment of substance abuse (alcohol or drug)
- Information about venereal disease(s)
- If I am an emancipated minor, information about treatment and diagnosis (except to my parents)
- Information related to mental health community program records
- Information about research involving controlled substances

_____ _____
Signature of Patient Date

If the patient is an unemancipated minor or otherwise incapacitated (physically or mentally), obtain the following signatures:

_____ _____ _____
Signature of Personal Representative | Description of Authority | Date

[If the Practice has requested this Authorization, provide a copy of the signed Authorization to the patient]