Gastro Health (Formerly Greater Boston Gastroenterology)
475 Franklin St., Suite 110, Framingham, MA 01702
Phone 508-620-9200 • Fax 508-620-6483 • GastroHealth.com/Framingham

Patient's Name_____ Date of Birth _____
(Please Print)

Address_____
(Street) (City/State) (Zip) (Phone)

I do hereby, authorize _____
(Name of Physician, Facility or Person)

Located at _____
(Street) (City) (State) (Zip)

to release protected health information, contained in the medical record of the above-named patient to the following:

_____
_____
_____

Is this a permanent transfer from the practice? Yes____ No____

Special Authorization for Release of Statutorily Protected Information from the Medical Record

I understand the following categories of information may be in the medical and ***SHOULD NOT*** be released UNLESS specifically authorized as indicated by my checking and initialing each appropriate category.

☐ ____Abortion	☐____ Behavorial/Mental Health	☐____ HIV/AIDS Results/Treatment
☐ ____Alcohol/Drug Abuse	☐____ Domestic Violence	☐____ Child/Elder/Disabled Abuse
☐ ____Rape/Sexual Assault	☐____ Genetic Testing	☐____ Sexually Transmitted Diseases

Information to be Released:

Dates of Treatment to be Released: _____ to _____ ☐ Laboratory Results ☐ XRay Reports Only

☐ Office Notes _____ ☐ Immunization Record ☐ Complete Record
(Specify Clinician(s))

☐ Other_____

I understand that once this health information is disclosed, the releasing facility cannot guarantee that the recipient will not redisclose my health information to a third party. 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 this Authorization in writing at any time and for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment. I understand that this authorization will expire 90 days from the date of said Authorization unless I provide a written notice of revocation to the release facility noted above.

_____ _____
Signature of Patient or Authorized Representative Date

_____ _____
Printed Name of Patient or Authorized Representative Relationship to Patient