GASTRO HEALTH

CONSENT FOR RELEASE OF MEDICAL INFORMATION

_____ _____
Patient Name Date of Birth

Information to be released from:

Name/Agency _____

Address_____

Phone_____ Fax_____

Information to be released to:

Name/Agency _____

Address_____

Phone_____ Fax_____

__Please send the entire medical record (all information) __Colonoscopy/Pathology reports only

__Laboratory reports __Clinician office chart notes __Diagnostic imaging reports

__Billing statements

__Other (specify)_____

I understand that information to be released may, unless noted above, include information regarding drug abuse, alcohol abuse, psychological or psychiatric impairments, HIV and/or AIDS, or physical conditions. If information pertaining to drug or alcohol abuse or treatment of the same has been disclosed, it has been done so from records protected by Federal confidentiality rules (45 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by 42 CFR Part 2. A general authorization for the release of medical or other information to criminally investigate or prosecute any alcohol or drug abuse patient.

I certify this authorization is made voluntarily. I understand that the information to be released is protected under state and federal laws and cannot be re-disclosed without my further written consent unless provided for by state and federal law. A copy may be accepted by the healthcare facility in lieu of the original.

I understand I may revoke this authorization at any time, except to the extent that action has already been taken. If not previously revoked, this consent will expire one year from the date of signature.

_____ _____
Signature of Individual or Individual's Legal Representative Date

_____ _____
Print Name of Legal Representative (if applicable) Relationship of Legal Representative to Individual

Chart Number _____