Northwest Gastroenterology
CLINIC & ENDOSCOPY CENTER

AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

I authorize to release a copy of the medical information for the below named patient:

NAME (please print): _____ DOB: _____ SSN: _____-____-_____

From: *Facility/MD:* _____

Address: _____

City, St, Zip: _____

Phone: _____ *Fax:* _____

To: Facility/MD: Northwest Gastroenterology Clinic, LLC
Address: 1130 NW 22nd Ave Ste 410
City, St, Zip: Portland OR 97210
Phone: (503) 229-7137 Fax: (503) 241-0628

*By **initialing** the spaces below, I specifically authorize the release of the following medical records to the facility named above, if such records exist:*

___*All Facility Records* ___*Office Chart Notes*

___*Lab Reports* ___*Most Recent History*

___*Pathology Reports* ___*Billing Statements*

___*Diagnostic Imaging Reports* ___ *Other:* _____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. ***I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.***

_____*HIV/AIDS information*
_____*Mental health information*
_____*Genetic testing information*
_____*Drugs/alcohol diagnosis, treatment, or referral information*

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDs information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive healthcare service or reimbursement for services. The only circumstances when refusal to sign means you will not receive healthcare services is if the health care service are solely for the purpose of providing information to someone else and the authorization is necessary to make that disclosure

You may revoke this authorization in writing at any time, if you revoke your authorization, the information described above may be no longer used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on authorization or the authorization was obtained as a condition of obtaining insurance coverage.

Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain effect for the period reasonably needed complete the request.

*SIGNATURE*_____ *DATE*____/____/___