Northwest Gastroenterology
CLINIC & ENDOSCOPY CENTER

Authorization to Release Information

Patient name_____ (Please print) _____ (DOB)

I authorize Northwest Gastroenterology to share my medical information with the designated personal representative listed below. I am aware I have the right to change my mind about sharing information with the designated person listed below. However, it's my responsibility to inform Northwest Gastroenterology of any change in writing.

_____ _____
(Designated Personal Representative) (*Relationship to patient*)

Time period

☐ Indefinite- This person should always have access.
☐ Specific period- This person should only have access from _____ to _____.

By marking the spaces below, I specifically authorize the person listed above to have access to my medical information or the ability to make changes as indicated.

Appointments:
_____ Access Appointment info i.e. Appointment time, date, location & reason for appointment.
____ Ability to make, reschedule and cancel appointments.

Medication:
____ Access to currently prescribed medication information.
____ Ability to request or cancel a refill.

Test results (Including but not limited to labs, radiology and pathology results)
___ Access to request test results.
___ Access to receive test results.

Financial information:
___ Access to billing info
___Ability to make payments or payment arrangements.

_____ (*Signature*) _____ (*Date*)