

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

To: Facility/MD: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, St, Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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 \_\_\_\_/\_\_\_\_/\_\_\_\_