Portland Gastroenterology CENTER

Authorization for Use and Disclosure of Protected Health Information

I, _____ Date of Birth: ____/ ____/ ____ authorize

Name: _____
Address: _____
City: _____ State: _____ Zip: _____

to use and/or disclose my Protected Health Information (PHI) and records of any treatment or examination rendered to me from: (dates of service) _____to _____.

To **Portland Gastroenterology Center**,
1200 Congress Street Suite 300
Portland, ME 04102
Ph (207)773-7964 Fax (207)773-9073

for the purposes of (specify the reason that this information is being released): _____

1. I understand that I may inspect or obtain a copy of the PHI described by this authorization.
2. I understand that PGC will not condition treatment, payment, or (if applicable) enrollment in the health plan or eligibility for benefits on my providing authorization for the requested use or disclosure AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION.
3. I understand that I may revoke this authorization in writing at any time by delivering such written revocation to the Privacy Officer of PGC. I also understand that such revocation will not be effective as to the disclosure of records whose release I have previously authorized or where other action has been taken in reliance on an authorization I have signed.
4. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

EXPIRATION DATE OR EVENT: This authorization will expire on (date no later than one year from now) _____ or the following event: _____

COPY PROVIDED: PGC shall supply a copy of this signed authorization to you upon your request. This information will be disclosed to you from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains. State law requires an individual or the individual's authorized legal representative to give specific consent for the release of protected health information related to certain disease conditions.
By my signature below, I authorize release of the following medical information that may be held by PGC:

☐ **Information pertaining to my HIV status**

☐ **Records of mental health care and treatment, records of abuse, records of care and treatment for sexually transmitted disease**

☐ **Records of substance abuse care and treatment**

___/___/___ _____
Date Signature of Patient or Legal Representative Relationship of Representative