Portland Gastroenterology CENTER

161 Marginal Way
Portland, Maine 04101
(207) 773-7964 • (207) 773-9073 fax
www.portlandgastro.com

Patient Request to Allow Disclosure of Protected Health Information to Health Plan

Patient Name _____ I.D.# _____ DOB: _____
(please print)

I _____ hereby request the following:
Patient and/or Patient Representative

To allow the disclosure of my PHI to my health plan, to _____, for the following health care item(s) and/or service(s):

_____

_____

_____

_____

_____
Signature of Patient and/or Patient Representative

_____
Print Patient and/or Patient Representative Name

Date _____

Requests must be submitted in writing to Portland Gastroenterology Associates, PA & Portland Endoscopy Center and if the request is denied, the patient and/or patient representative will be informed as to the reason why. Portland Gastroenterology Center cannot adhere to a patient request to allow disclosure of PHI to their health plan if the disclosure is required by law. Please contact Portland Gastroenterology Center in writing to revoke this authorization.

FOR OFFICE USE ONLY ❑ Approved ❑ Denied

Request received by: _____ Date: _____