Portland Gastroenterology CENTER

161 Marginal Way
Portland, Maine 04101
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Patient Authorization for Use and Disclosure of Protected Health Information

Patient Name _____ Phone Number _____

Address _____

Date of Birth _____ Medical Records # _____

❑ I hereby authorize Portland Gastroenterology Associates, PA & Portland Endoscopy Center to disclose the following health information to:

Name _____

Address _____

Phone _____ Fax _____

❑ I hereby authorize: Name _____

Address _____

Phone _____ Fax _____

to disclose the following health information to Portland Gastroenterology Center.

1. Information to be disclosed:
   - ❑ Medical record from this date _____ to this date _____.
   - ❑ Entire medical record

     Comments: _____
2. Purpose for release of records: _____
3. To the extent applicable, I understand that my medical record may contain information that is considered sensitive under the law. My check mark(s) below indicate(s) that I do NOT permit information of this type, if it exists, to be released. I understand that if I do not check the box, Portland Gastroenterology Center will release such information about me if it exists.

   ❑ HIV/AIDS infection ❑ Mental Health ❑ Treatment for alcohol and/or drug abuse
   ❑ Genetic Information ❑ Sexually transmitted diseases
4. I understand my records are protected under the federal privacy laws and regulations and under state law, and cannot be disclosed without my written consent except as otherwise specifically provided by law.
5. It is my understanding that this authorization will expire in one (1) year from the date signed below. I understand that I may revoke this authorization by notifying Portland Gastroenterology Center. I understand that any previously disclosed information would not be subject to my revocation request.
6. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits, unless otherwise described in the space provided here: _____
7. I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may be subject to federal or state law protecting its confidentiality.
8. I understand that I may inspect or obtain a copy of the PHI described by this authorization.

This form must be fully complete before signing.

_____ _____
Signature of Patient or Patient's Legal Representative Date

_____
Print Patient's Name

_____
Print Name of Legal Representative (if applicable)

_____
Relationship to Patient