UNIVERSITY GASTROENTEROLOGY

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PATIENT AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

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Bridget Fitzgibbon, APRN
Mary Fortuna-Silva, APRN
Colleen Fullerton, APRN
Virginia Pierce, APRN
Kristin Skelly, APRN
Miguel Zaplano, APRN

Doctor: ______________________________

Patient: ______________________________
(First Name) *(Middle Initial)* *(Last Name)*

Street Address: ______________________________

City: ____________ **State:** ____________

Patient's Date of Birth: ______________________________

University Gastroenterology is authorized to:

☐ furnish to **OR** ☐ obtain from: (please select one)

Name of Recipient: ______________________________

Address: ______________________________

Phone #: ____________ **Fax:** ____________

For the purpose of: (Circle one) **Transfer of Care** **Continuity of Care** **Second Opinion**

(Optional)

Medical Records (Excluding Sensitive Information)

☐ Information and records or copies of records relating to the history, treatment or services rendered to me with in connection with any condition or disease beginning ___/___/_____ and ending ___/___/____ and, if necessary, allow them or any physician appointed by them to examine any x-rays or other diagnostic records which the facility may have regarding my condition or treatment during this period.

Only those specific records, as described below:

____

____

Sensitive Information

☐ I hereby specifically _____ consent to or _____ refuse the disclosure and release of "sensitive medical information" concerning my treatment of mental illness, HIV, alcoholism, drug abuse/dependency, venereal disease, sexual assaults, abortion, illegitimacy of birth, communications to social workers and or psychotherapists/psychologists, if any.

*I release **University Gastroenterology, LLC,** from all responsibility or liability that may arise from this authorization. I may withdraw this authorization at any time by giving written notification to **University Gastroenterology, LLC.***

This authorization expires on ___ /___ / ____ (Optional) If no expiration date is given, this authorization shall remain in effect for a period reasonably needed to complete the request.

Patient's Signature: (or representative, if a minor):______________________________

Relationship, if not patient: ____________ Date: ____________

Witness Signature: ____________ Date: ____________