1035 Wellington Ave • Grand Junction, CO 81501
Phone: 970-242-6600 • Fax: 970-241-8443

Authorization to Use or Disclose My Health Information

Patient Name: ________________________________ DOB: ________________________________

Previous Name: ________________________________ Social Security Number: ____________________

☐ I Authorize Grand Junction Gastroenterology to **REQUEST** medical records from:

Name (or title) and organization ________________________________ Phone: ____________________

Address ______________________ City __________ State _____ Zip _______ Fax: ____________

☐ I Authorize Grand Junction Gastroenterology to **RELEASE** my medical records to:

Name (or title) and organization ________________________________ Phone: ____________________

Address ______________________ City __________ State _____ Zip _______ Fax: ____________

1. My Authorization
You may use or disclose the following health care information (Check One)

☐ All of my health information maintained by Grand Junction Gastroenterology and Endoscopy Center
Circle any of the following you ***do not*** want included with your records. (otherwise, all will be sent)
My health information related to:

Drug abuse **HIV / AIDS**

Alcohol abuse **Psychological or psychiatric conditions, including psychotherapy notes.**

☐ My health information for the date(s) ____

Reason for request

☐ Transfer of care: ______________________________

☐ Continuation of care: __________________________

☐ Other: ______________________________________

2. My Rights
I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- **To take part in a research study or**
- **To receive health care when the purpose is to create health information for a third party.**

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. The form is available from the office, or
- Write a letter to the office

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

______________________________ ____________________ ______________

Patient or legally authorized individual signature **Date** **Time**

______________________________ ____

Printed name if signed on behalf of the patient **Relationship (parent, legal guardian, personal representative, etc)**

This authorization is good for 1 year from the signed date. *Revised 05/04/2011*