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

Authorization to Use or Disclose Protected Health Information

Patient Name: ____ DOB: __________________________

Previous Name: ____ Social Security # __________________

Reason for request/release

☐ Personal use (Please allow up to 14 days for processing)
☐ Continuation of care
☐ Transfer of care
☐ Other: _________________________

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

Name of organization _________________________ Phone: __________________ Fax: ________________

Address ___________________________ City _____________________ State ______ Zip_______________

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

Name of person or organization _________________________ Phone: ________________________

Check all that apply:

☐ All my health information maintained by Grand Junction Gastroenterology

Specifically: ☐ Clinic Notes ☐ Lab/Pathology Results ☐Radiology Results ☐ Procedure Report

☐ Other: _________________________

With the exceptions of: ____

For the date(s) of: _________________________________

By means of:

☐ Fax to ________________________

☐ Encrypted email to ____

☐ In office pick up by ______________________________

☐ Mailed to ________________________________

Address _________________________ City __________________ State ____ Zip_________

I understand that once the office discloses my health information, the person or organization that receives it may re-disclose it and privacy laws may no longer protect it. This authorization is valid for 1 year. I can revoke this authorization at any time by providing a written notice of revocation.

____ ________________________

Signature of patient or legally authorized individual Date

____ ________________________

Printed name Date