Granite State GASTROENTEROLOGY

Office: 603-432-8802 Fax: 603-437-0118

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Full Name: _____ **DOB**: _____

I hereby authorize **Granite State Gastroenterology** to __ **RELEASE TO** or __ **RECEIVE FROM** (please check one)

FACILITY/PROVIDER NAME: _____

PHONE: _____ FAX: _____

INFORMATION TO BE DISCLOSED: Please specify dates if applicable, or check "ALL" for all records.

__ All
__ Office Notes Date: _____
__ Imaging Results Date: _____
__ Surgical Reports (Please Specify): _____
__ Hospital Discharge Summary– Date: _____
__ Lab Results Date: _____
__ Cardiac Testing – Date: _____
__ _____

PURPOSE: I authorize Granite State Gastroenterology to use and disclose my health information (including any highly confidential information unless otherwise specified above) during the term of this Authorization for the following specific purposes:

☐ Transferring Out of Practice (reason): _____
☐ Personal Use
☐ Insurance / Disability
☐ Continuity of Care
☐ Attorney / Legal Case

I understand that I may inspect or obtain a copy of the protected health information described by this authorization. I understand that Granite State Gastroenterology will not condition treatment, payment, or (if applicable) enrollment in the health plan or eligibility for benefits on my providing authorization for the requested use or disclosure. I also understand that I may refuse to sign this authorization. I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION IN WRITING AT ANY TIME BY DELIVERING SUCH WRITTEN REVOCATION TO THE Privacy Officer of Granite State Gastroenterology. I also understand that such revocation will not affect the disclosure of records whose release I have previously authorized, or where other actions have been taken in reliance on an authorization I have signed. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and, if so, may no longer be subject to federal or state law protecting its confidentiality.

_____ _____ _____

Signature of Patient or Representative | Date | Relationship of Representative to Patient

EXPIRATION DATE: This authorization will expire one year from the signed date.