Granite State GASTROENTEROLOGY

CONSENT TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____ **DOB:** _____

I authorize **Granite State Gastroenterology (GSG)** to release confidential information regarding my healthcare, including test results to the following individuals:

Name(s) of Authorized Person(s):

Name	**Relationship**	**Phone Number**
_____	_____	_____
_____	_____	_____

OR

❑ **No information is to be disclosed to anyone other than myself.**
(Initial here: _____)

I authorize GSG to disclose my healthcare information as follows:

❑ I authorize GSG to leave results on my answering machine at home.
❑ I authorize GSG to leave results on my cell phone voicemail.

Please list any exceptions or additional instructions here:

This authorization will remain in effect permanently unless I provide written notification of a change.

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