



Advanced Gastroenterology, PLLC  
 Advanced Endoscopy, PLLC  
 2415 NE 134<sup>th</sup> Street, Suite 205  
 Vancouver, WA 98686  
 360-576-5060

**AUTHORIZATION FOR RELEASE OF INFORMATION**  
 PLEASE PRINT CLEARLY

Patient Name: \_\_\_\_\_ Birth date: \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

SSN: \_\_\_\_\_ Daytime Phone: (\_\_\_\_) \_\_\_\_\_ Cell/Work Phone: (\_\_\_\_) \_\_\_\_\_

I authorize you to **OBTAIN** health care information **FROM:**

\_\_\_\_\_  
 Physician Name

\_\_\_\_\_  
 Clinic/Hospital Name

\_\_\_\_\_  
 Street/Box

\_\_\_\_\_  
 City/State/Zip

Fax: (\_\_\_\_) \_\_\_\_\_

I authorize you to **SEND/DISCLOSE** health care information **TO:**

Self/Patient

\_\_\_\_\_  
 Physician Name

\_\_\_\_\_  
 Clinic/Hospital Name

\_\_\_\_\_  
 Street/Box

\_\_\_\_\_  
 City/State/Zip

Fax: (360) 576-1133  **PLEASE FAX RECORDS**

**You may use/disclose the following information:**

- All health care information in my medical record
- Health care information relating to the following treatment or condition: \_\_\_\_\_
- Health care information for the date(s): \_\_\_\_\_
- Immunization information
- Radiology films-date(s) or type(s): \_\_\_\_\_
- Other: \_\_\_\_\_

**You may use or disclose health care information regarding testing, diagnosis and treatment for (check all that apply):**

- HIV, HIV-related illness, AIDS, Aids-related illness
- Sexually transmitted diseases
- Psychiatric disorders/mental health treatment
- Drug and/or alcohol use

**Reason for Disclosure:**  Referral/second opinion  Transfer or Care  Insurance application/benefits

**This authorization ends (this document does not permit disclosure of health information created more than 90 days after the date it is signed):**

- 90 days from date it is signed  On (date): \_\_\_\_\_
- When the following occurs (no longer than 90 days from date signed): \_\_\_\_\_

I understand that 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 care information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Advanced Gastroenterology based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. I may revoke this authorization by writing a letter to Advanced Gastroenterology. Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it. **There may be fees for providing copies.**

\_\_\_\_\_  
 Patient or legally authorized representative signature

\_\_\_\_\_  
 Date and time

\_\_\_\_\_  
 Relationship to patient (if not by patient)

\_\_\_\_\_  
 Printed name if signed on behalf of patient