Advanced Gastroenterology, PLLC
Advanced Endoscopy, PLLC
2415 NE 134th 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 _X_ 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