Gastroenterology Associates

Gastroenterology and Hepatology
olygastro.com

MEDICAL RECORDS RELEASE
(Combined Authorization to Use or Disclose Protected Health Information for Research)

Complete all sections, date and sign

Patient Name: _____ **Date of Birth:** _____
(Please print or type)

Previous Name: _____ **Phone Number:** _____

I. My Authorization: Gastroenterology Associates may use or disclose the following health care information (check all that apply):

☐ Health care information in my medical record relating to the following treatment or condition (specify):_____

_____

☐ Health care information in my medical record for the date(s): From:_____ To:_____
☐ Other (e.g., x-rays, billing. specify date(s): From:_____ To:_____
☐ All health care information in my medical record

II. Uses and Disclosures Requiring Specific Authorization - You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

☐ Treatment of Alcohol and/or Drug Abuse ☐ HIV/AIDS
☐ Sexually Transmitted Diseases ☐ Mental Health/Psychiatric Disorders (other than Psychotherapy notes)

III.

Health care information is to be disclosed from:		**Health care information is to be disclosed to:**	
Name of Facility		Name of Person/Organization/Facility	
Address		Address	
City/State/Zip		City/State/Zip	
Phone:	Fax:	Phone:	Fax:

IV. You are authorized to use or disclose my health care information for research, as described and designated below: (check all that apply):

Conditioned Research

☐ The following research studies and/or activities for which this authorization is required in order for me to receive research-related treatment (describe one or more research studies or activities for which this authorization is required in order to receive research-related treatment):

_____

_____

Unconditioned Research

☐ The following research studies and/or activities for which this authorization is not required in order for me to receive treatment, payment, enrollment, or eligibility for benefits (describe one or more research studies or activities for which this authorization is not required in order to receive treatment, payment, enrollment, or eligibility for benefits):

_____

_____

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V. This authorization ends:

☐ On (date): _____
☐ End of the research studies
☐ When the following event occurs: _____
☐ When the research database or other research-related repository no longer operates or uses my health care information

VI. My Rights:

1. I understand that I **do** have to sign this authorization:
   a. in order to receive research-related treatment in connection with the Conditioned Research studies or activities listed above, or
   b. in order to receive health care when the purpose is to create health care information for disclosure to a third party
2. I understand that I **do not** have to sign this authorization in connection with the Unconditioned Research studies or activities listed above in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits).
3. I may revoke this authorization in writing at any time. If I did, it would not affect any actions taken by Gastroenterology Associates in reliance on this authorization before it receives my written revocation. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:
   a. Fill out a revocation form. A form is available from Gastroenterology Associates, or
   b. Write a letter to Gastroenterology Associates.

VII. Protection after Disclosure. I understand that once my health care information is disclosed, the person or organization that receives it may re-disclose it and that privacy laws may no longer protect it.

_____ _____ _____
Patient or legally authorized individual signature | Date | Time

_____ _____
Printed name if signed on behalf of the patient | Relationship (parent, legal guardian, personal representative)