West Suburban Gastroenterology
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Authorization to Release Health Information

Patient Name: _____

Date of Birth: _____

Patient Full Address: _____

Patient Phone Number: _____

Purpose: _____

I authorize the release of my health information because I have an upcoming evaluation/consultation with

_____

Information to be disclosed:

_____

_____

I authorize the release of the above-mentioned health medical records that the provider has in their possession, including information relating to any medical history, mental or physical condition and any medical treatment received by me.

Records to be released from: _____

Records will be released to: _____

Terms
I understand that this authorization will remain in effect for 1 year from the date signed below and if I chose to revoke this release I will need to do so in writing. I understand that my healthcare provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to Sign/Right to Revoke
I understand that signing this form is voluntary and that if I do not sign it will not affect the commencement or continuation of my treatment. If I change my mind, I understand that I can revoke this authorization by providing written notice of revocation to West Suburban GI. The revocation will be effective immediately upon my written request, unless the action has already been completed by West Suburban GI.

Patient Name: _____

Patient Signature: _____ **Date:** _____

Name of Legal Guardian/Health Care Proxy: _____

Signature of Legal Guardian/Healthcare Proxy: _____ **Date:** _____