GASTROENTEROLOGY ASSOCIATES, INC.
44 West River Street
Providence, RI 02904
P: 401-274-4800
F: 401-454-0410

Authorization for the Release of Confidential Health Care Information

Patient Name _____ Phone Number _____

Date of Birth _____ Social Security _____

Address _____

I authorize Gastroenterology Associates, Inc. to: ☐ **Obtain from** **OR** ☐ **Release to**

_____
(Name of Person / Place / Institution)

_____
(Address)

Purpose for which disclosure is to be made:

_____

Information to be disclosed

☐ Entire medical record
☐ Consultation / office notes
☐ Pathology Reports
☐ Radiology Reports
☐ Other _____

Please check one: I hereby

☐ **Consent** ☐ **Refuse**

to the release of confidential information concerning: mental health, alcohol and/or drug use, sexual abuse, venereal disease, AIDS or HIV test results.

I understand that my records are protected under the Federal Confidentiality Regulation and under the General Laws of Rhode Island, and cannot be disclosed without my written consent except as otherwise specifically provided by law.

Any information to be released or received that is authorized by my consent evidenced by this document shall not be given, transferred or relayed in any manner to any other person, either in an individual or representative capacity, without an additional written consent.

I understand that I may withdraw this consent by giving written notification to Gastroenterology Associates at any time prior to the disclosure or release of the information. In the absence of my prior withdrawal, this consent will expire 90 days after it is signed.

_____ _____
Signature of Patient Date

_____ _____
Print Name of Legal Representative (if applicable) Relationship to Patient