Roaring Fork
GASTROENTEROLOGY P.C.

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Date: _____ **Patient DOB:** _____

Patient Name: _____ **Patient SS# (last four digits)** _____
(Please Print)

I do hereby authorize Roaring Fork Gastroenterology, PC to OBTAIN From: RELEASE To:
(Circle appropriate option)

Name of Facility/Provider: _____
Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Phone: (_____) _____ Facsimile: (_____) _____

Communication with Family or Persons Involved in Your Care: We may disclose medical information about you verbally to a relative, close friend or any other person you identify in writing, if that person is involved in your care and the information is relevant to your care with a clear written authorization. We may also disclose without written authorization any medical information about you with a relative, close friend or any other person involved in your care who may be invited into the exam room at the time of your appointment, or possibly a disaster relief organization, if we need to notify someone about your location, your general condition or in the event of your death. You may ask us at any time not to disclose medical information about you to persons involved in your care.

❑ **Verbal Authorization/ Consent:** This consent must be in writing to be valid when verbal consent is acceptable. Verbal consent may also be accepted in specific emergency situations.

I authorize the above-named healthcare facility/provider to release the information specified below to the organization, agency, or individual named on this request. I specifically authorize the release of information regarding the following conditions(s):

❑ **Drug Abuse** ❑ **Alcohol Abuse** ❑ **Psychological or Psychiatric Conditions**

*Alcohol or Drug Abuse Statement must be attached to any disclosure of this information from a federally assisted alcohol or drug abuse program. Any oral disclosure shall be accompanied or followed by such statement.

Information Requested:	**Condition(s) and Dates of Care Covered:**
❑ Copy of History & Physical, Discharge Summary, Op Reports ❑ Copy of Out-Patient or ER Admission ❑ Billing Records ❑ Copy of Complete Medical Record for the Past _____ year(s) ❑ Other (specify) _____	❑ All Past Admissions or Care at this Facility ❑ Limited to Treatment date(s) and Conditions described here: _____ _____ _____

Purpose(s) or need for which information is to be used: ❑ For Continuing Treatment / Referral / Specialist ❑ Workers Compensation

❑ Injury or Claim Evaluation ❑ Insurance or Payer Claim ❑ Other _____

Expiration or Revocation of Authorization – I understand that I may revoke this authorization at any time in writing, except to the extent that action has already been taken. Without my previous expressed revocation, this authorization will automatically expire in _____months.
(**This may not exceed a twelve month period from the date of this authorization**)

_____ _____
(**Patient or Authorized Representative Signature**) (**Date signed**)

A copy of this authorization with my signature may be utilized with the same effectiveness as an original. If authorized representative signing, must submit a copy of the legal documentation to support their signature (i.e.: Medical Durable POA, Death Certificate, Legal Guardian, Personal Representative by Court Order, etc.)