Bedford
GASTROENTEROLOGY

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Full Name: _____ DOB: _____

I hereby authorize _____to use and/or disclose my Protected Health Information.

Entity to which information is being released to: _____

Specify the reason that this information is being released: _____

Identify specific information to be released: _____

Identify specific information you do not want released: _____

Dates of care included: _____ to: _____

1. I understand that I may inspect or obtain a copy of the protected health information described by this authorization.

2. I understand that Bedford Gastroenterology will not condition treatment, payment or (if applicable) enrollment in the health plan or eligibility for benefits on my providing authorization for the requested use or disclosure **AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION.**

3. I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION IN WRITING AT ANY TIME BY DELIVERING SUCH WRITTEN REVOCATION TO THE Privacy Office of Bedford Gastroenterology.
   I also understand that such revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed.

4. I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Date: _____

_____ _____

Signature of Individual Patient or Representative Relationship of Representative to Patient

EXPIRATION DATE: This authorization will expire one year from the date it was signed.