Bedford
GASTROENTEROLOGY

CONSENT TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____ **DOB**:_____
(Please Print)

I authorize Bedford Gastroenterology (BG) to release confidential information regarding my health care, including my test results, to the following individuals:

Name of authorized person(s):	Relationship	Phone Number
_____	_____	_____
_____	_____	_____

Or **NO** information to be given out to anyone other than myself. Initial_____

_____I authorize BG to leave any results on my answering machine at home.

_____I authorize BG to leave any results on my cell phone voicemail.

_____I authorize BG to mail my results to my home.

Please list any exceptions or instructions: _____

_____

This authorization will be considered permanent unless we are notified in writing of any change.

_____
(Patient/Parent/Guardian Signature) Date (Relationship)