COLORADO GASTROENTEROLOGY
A PROFESSIONAL LLC
CONSULTANTS IN LIVER AND DIGESTIVE DISEASES

Authorization to Disclose Health Information

I authorize Colorado Gastroenterology to release the health information of the individual named below:

Patient name: _____ Date of Birth: _____

I authorize the information to be disclosed to and used by the following individual or organization:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

When ready: ___ Pick-up ____ Mail ____ Fax Fax Number: _____

The type and amount of information to be disclosed:
____ All of my health information maintained by Colorado Gastroenterology
____ My health information related to the following condition: _____
____ My health information for the date(s): _____
____ Other (specify): _____

Purpose of disclosure:
____ For my records
____ Other (specify): _____

I understand that I do not have to sign this form in order to receive health care benefits (treatment, payment or insurance plan enrollment).

I understand that the medical information released by this organization may include information concerning treatment of physical and mental illness, alcohol/drug abuse and past medical history.

I understand that this authorization will expire one year from the date of signing. I understand that I may revoke this authorization in writing at any time. If I do, it will not affect any actions already taken by the above named practice based upon the authorization or to my insurance company when the law provides my insurer the right to contest a claim under my policy or the policy itself.

I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

_____ _____
Signature of Patient of Authorized Personal Representative Date

_____ _____
Printed Name of Personal Representative Relationship