NORTHEASTERN GASTROENTEROLOGY ASSOC.,PC
1860 FAIR AVENUE SUITE A
HONESDALE, PA 18431-2108

Phone: 570-253-3391 Fax: 570-253-1811

Patient Authorization for Release of Medical Records

Patient's Name:
Address:

DOB:

Please check all information that applies:
☐ Chart Notes
☐ MRI report
☐ X-rays
☐ CAT Scan
☐ Other (please specify):

☐ I give my authorization to release the above protected information to NORTHEASTERN GASTROENTEROLOGY ASSOC.,PC My medical records are being requested from:
NAME:
ADDRESS:
FAX NUMBER:

☐ I am authorizing NORTHEASTERN GASTROENTEROLOGY ASSOC.,PC to disclose or release the above protected information to the following person or organization. The following will receive and use my protected health information:
NAME:
ADDRESS:
FAX NUMBER:

Purpose for disclosing information: **CONTINUATION OF CARE**

Select one of the following choices:
☐ This authorization will end on the following date:
(Unless otherwise revoked, this authorization will expire 60 days from the date of signature.)

☐ This authorization will end when the following event happens. The event must relate to the individual or the purpose of the authorized use/or disclosure. Describe the event below:

I understand that I may revoke this authorization at any time by notifying the providing organization in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. The facility, its employers and officers and attending physician are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein. I understand that if the organization/individual authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

I understand that my health care and the payment for my health care will not be affected if I do not authorize this disclosure. I understand that I will be given a copy of this authorization form, after signing.

Signature of Patient:
Name of Patient:
Date: