Advanced Gastroenterology Associates
Atlantic Coast Gastroenterology Associates
Gastroenterologists of Ocean County
Middlesex Monmouth Gastroenterology
Monmouth Gastroenterology
Red Bank Gastroenterology Associates
Shore Gastroenterology Associates

Records Release Authorization for use and disclosure of Protected Health Information (PHI)

I am requesting protected health information/ records to be released for the following person:

Patient Name: ______________________________ Birthdate: ____/____/____

Phone: _____-_____-_____ Maiden or other name: ______________________________

Please release medical records/Information from:

Physician's Name(s): ______________________________

Practice: ______________________________ Phone: ______________ Fax: ______________

I am authorizing the following medical information (check all that apply) be released/disclosed:

☐ All ☐ Operative Reports ☐ Pathology Reports ☐ Lab Results ☐ Radiology Reports ☐ Hospital Records

Other, specific dates of treatment or procedures: ______________________________

Please forward the requested medical records/ information to:

Name: ______________________________ Phone: ______________ Fax: ______________

Address: ______________________________

Signature Authorization:

- I understand that I have the right to revoke this authorization at any time.
- I understand that my revocation must be in writing and addressed to the Privacy Officer of the above named facility authorized to make this disclosure.
- I understand that the revocation does not apply to information that has already been released in response to this authorization.
- Unless otherwise revoked this authorization will expire in two months or on this date listed ____________.
- I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State law.
- I understand that I need not sign this authorization to assure treatment.
- I understand that I may inspect and/or copy the information to be disclosed.
- I understand that authorizing is voluntary. I understand that if I have any questions about disclosure of my health information, I may contact the Allied Digestive Health Privacy Officer who is authorized to disclose this information and request a copy of this authorization.
- I understand that the information in my health record may include information pertaining to treatment of drug and alcohol abuse, mental health, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis information or genetics. THIS INFORMATION WILL ALSO BE RELEASED UNLESS YOU INDICATE; __ DO NOT RELEASE (Indicate with a check mark).

I understand, consent and agree to these statements:

______________________________ ______________
Signature of Patient or Guardian | Date

______________________________ ______________
Representatives Authority to Act on Behalf of Patient | Signature of Witness

Allied Digestive Health
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