

# Grand Junction Gastroenterology & Endoscopy Center

1035 Wellington Ave • Grand Junction, CO 81501  
Phone: 970-242-6600 • Fax: 970-241-8443

## Authorization to Use or Disclose My Health Information

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Previous Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

I Authorize Grand Junction Gastroenterology to **REQUEST** medical records from:

Name (or title) and organization \_\_\_\_\_ Phone: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Fax: \_\_\_\_\_

I Authorize Grand Junction Gastroenterology to **RELEASE** my medical records to:

Name (or title) and organization \_\_\_\_\_ Phone: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Fax: \_\_\_\_\_

### 1. My Authorization

You may use or disclose the following health care information (Check One)

All of my health information maintained by Grand Junction Gastroenterology and Endoscopy Center  
Circle any of the following you **do not** want included with your records. (otherwise, all will be sent)  
My health information related to:

**Drug abuse**

**HIV / AIDS**

**Alcohol abuse**

**Psychological or psychiatric conditions, including psychotherapy notes.**

My health information for the date(s) \_\_\_\_\_

### Reason for request

Transfer of care: \_\_\_\_\_

Continuation of care: \_\_\_\_\_

Other: \_\_\_\_\_

### 2. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- **To take part in a research study or**
- **To receive health care when the purpose is to create health information for a third party.**

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. The form is available from the office, or
- Write a letter to the office

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

\_\_\_\_\_  
Patient or legally authorized individual signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

\_\_\_\_\_  
Printed name if signed on behalf of the patient

\_\_\_\_\_  
Relationship (parent, legal guardian, personal representative, etc)

*This authorization is good for 1 year from the signed date.*

*Revised 05/04/2011*