Milford Gastroenterology Associates
Authorization for Release of Information

Patient Name: _________________________________ Date of birth: ______________

Address: ______________________________________ Phone: ___________________

I authorize the use and/or disclosure of the above-named individual's health information as described in this authorization.

Person/organization releasing/requesting the information:

Milford Gastroenterology Associates

215 West St.

Milford, MA 01757

Phone: 508-478-6363

Fax: 508-473-2636

Person/organization requesting/releasing the information:

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____

Phone: __________________________

Fax: ___________________________

The information to be used/disclosed:

____

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The purpose of the request: (each purpose must be listed)

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(   ) At the request of the individual for his/her own purposes.

I understand that I have the right to revoke (cancel) this authorization at any time. I understand that to revoke this authorization, I must do so in writing and send my written revocation (cancellation) to Milford Gastroenterology Associates. I understand that the revocation will not be effective until it is received, and it will not apply to information that has already been released in response to this authorization. I also understand that a revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise revoked, this authorization will expire 180 days after the date signed below. By signing below, I acknowledge that I have read and understand this authorization and, if I have any questions about disclosures of my protected health information, I may contact Milford Gastroenterology Associates.

I understand that signing this authorization is voluntary and that Milford Gastroenterology Associates will provide treatment and pursue payment for services regardless of whether I sign this authorization. However, if my treatment is related to a research study or solely for the purpose of providing information about my health or medical condition to someone else, Milford Gastroenterology Associates may require that I sign this authorization before it provides treatment to me.

I understand that if I authorize Milford Gastroenterology Associates to disclose information, the recipient if the information might disclose it to others, and that any information disclosed by Milford Gastroenterology Associates may no longer be protected by the federal rule on the privacy of medical records.

Signature of patient*
or patient's representative: ______________________________ Date: ______________

(Form must be completed before signing)

Printed name of patient
or patient's representative: ______________________________ Date: ______________

**If the patient is under age 18 and is not an emancipated minor, the parent or legal guardian (with proof of authority) must sign this document. If the patient is over age 18, the patient is considered of legal age in Massachusetts and must authorize the release of his/her records.*

You may refuse to sign this authorization form.

Please note that Milford Gastroenterology Associates will charge a fee for copies of medical records when requested for personal use.