

**GREATER BOSTON GASTROENTEROLOGY**

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**Authorization for Use or Disclosure of Patient’s Health Information**

*We may require up to two weeks to process medical record requests.*

*There may be a fee for processing medical record releases.*

I hereby authorize *Greater Boston Gastroenterology* to use or disclose the below named patient’s health information as described below.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

I authorize *Greater Boston Gastroenterology* to use or disclose my health information to the following individual(s) or organization:

\_\_\_\_\_

Address: \_\_\_\_\_

The health information to be used or disclosed is as follows (describe dates of service, information to be disclosed, etc ):

\_\_\_\_\_

Are you transferring out of this practice? YES \_\_\_\_\_ NO \_\_\_\_\_

Unless otherwise revoked, this authorization will expire on: \_\_\_\_\_

**I understand that I have the right to revoke this authorization at any time. To revoke this authorization, I must present a written revocation to the office of Greater Boston Gastroenterology. A more detailed description of the right to revoke an authorization and how to exercise that right can be found in *Greater Boston Gastroenterology’s Notice of Privacy Practices.***

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form to ensure treatment, payment, enrollment, or eligibility for benefits. I understand that there is the potential for information used or disclosed under this authorization to be redisclosed by the recipient and that the redisclosure may not be protected by the federal health information privacy regulations. If I have questions about the disclosure of my health information, I can contact the office of *Greater Boston Gastroenterology.*

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date