

GREATER BOSTON GASTROENTEROLOGY

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

- I hereby authorize the use or disclosure of the below named patient's health information as described below:

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

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

- I authorize \_\_\_\_\_  
to use or disclose my health information to: *Greater Boston Gastroenterology*.

- The health information to be used or disclosed is as follows (describe dates of service and information to be disclosed): \_\_\_\_\_

❖ 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 release.**

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.

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

\_\_\_\_\_  
Date