ROCKFORD GASTROENTEROLOGY ASSOCIATES

Authorization for Release of Confidential Health Information

Patient Name: _____SS#:_____-_____-_____Date of Birth: _____/_____/_____

Address: _____City/State/Zip: _____

Phone #: (_____)_____-_____

I, the above patient authorize:

Rockford Gastroenterology Associates
401 Roxbury Road
Rockford, IL 61107
Fax: 815-397-7388

☐ To Furnish to ☐ Receive from:

_____
(Name of Healthcare Facility, Physician, Agency, etc.)

_____
Address

_____
City/State/Zip

(_____)_____ (_____)_____
Phone # Fax #

The Following Information:

Check one:

- ☐ Complete Chart
- ☐ All GI Related Records
- ☐ Other:_____

For the Following Time Period:

From: _____ to _____

This disclosure is made for: _____

(Personal Records, Further Care, Transfer of Care, Insurance, Legal Counsel, Disability)
Transfer of care is only used for patients that will no longer receive services from RGA

- **I understand** that my medical records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about a behavioral or mental health service, developmental disabilities, or treatment for alcohol and/or drug abuse.
- **I understand** that information disclosed pursuant to this Authorization might be re-disclosed by the recipient and may no longer be protected by federal or state law.
- **I understand** that I may revoke this authorization at any time by notifying the privacy officer of RGA in writing. Notwithstanding the foregoing, I understand that I may not revoke this authorization to the extent that RGA has taken action in reliance upon it.
- **I understand** that I may refuse to sign this authorization and that my refusal to sign in no way affects my ability to receive treatment.
- **I understand** that this authorization shall expire, without my revocation, one year following the date of signature unless otherwise indicated.

Signature of Patient or Patient Representative **Date**

Signature of Witness **Date**

For Office Use Only

Release has been sent by: Fax Mail on:_____/_____/_____ by: _____

Records Released by: Fax Mail on:_____/_____/_____ by: _____

Patient picked up records on site ☐