GREATER BOSTON GASTROENTEROLOGY
475 FRANKLIN STREET, SUITE 110
FRAMINGHAM, MA 01702
Phone (508) 620-9200 Fax (508) 620-6483

Patient's Name___________________________________ Date of Birth ____________________________
(Please Print)

Address____
(Street) (City/State) (Zip) (Phone)

I do hereby, authorize ____
(Name of Physician, Facility or Person)

Located at ____
(Street) (City) (State) (Zip)

to release protected health information, contained in the medical record of the above-named patient to the following:

____
____
____

Is this a permanent transfer from the practice? Yes____ No____

Special Authorization for Release of Statutorily Protected Information from the Medical Record

I understand the following categories of information may be in the medical and ***SHOULD NOT*** be released UNLESS specifically authorized as indicated by my checking and initialing each appropriate category.

☐ ____Abortion	☐_____ Behavorial/Mental Health	☐_____ HIV/AIDS Results/Treatment
☐ ____Alcohol/Drug Abuse	☐_____ Domestic Violence	☐_____ Child/Elder/Disabled Abuse
☐ ____Rape/Sexual Assault	☐_____ Genetic Testing	☐_____ Sexually Transmitted Diseases

Information to be Released:

Dates of Treatment to be Released: _____________ to _____________ ☐ Laboratory Results ☐ XRay Reports Only

☐ Office Notes _____________________________ ☐ Immunization Record ☐ Complete Record
(Specify Clinician(s)

☐ Other____

I understand that once this health information is disclosed, the releasing facility cannot guarantee that the recipient will not redisclose my health information to a third party. Such third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that I may refuse to sign or may revoke this Authorization in writing at any time and for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment. I understand that this authorization will expire 90 days from the date of said Authorization unless I provide a written notice of revocation to the release facility noted above.

_____________________________________ _____________________________
Signature of Patient or Authorized Representative Date

_____________________________________ _____________________________
Printed Name of Patient or Authorized Representative Relationship to Patient