Coastal Gastroenterology, APC

AUTHORIZTION FOR USE/DISCLOSURE OF HEALTH INFORMATION

I voluntarily authorize and direct the health care provider named below to disclose my health information during the term of this authorization to the recipient that I have identified below:

Dr / Group Name:_____

Address:_____

_____

Phone:_____ Fax:_____

To furnish copies of my records listed below to
Coastal Gastroenterology
700 Garden View Court Suite 102 Encinitas, Ca 92024 or
fax to 760-635-5972

Information to be disclosed: This authorization permits the above name health care provider to disclose the following medical records:

__ All of my health information that the provider has in his or her possession, including information related to any medical history, mental or physical condition and any treatment received by me, including without limitation, x-rays, HIV/AIDS status, genetic testing, psychotherapy notes and other mental health information, drug, alcohol or other controlled substance information, billing information, correspondence, and records from my other health care providers that the above-named health care provider may hold.

__ All of my health information described above except for the following:

__Only the following records or types of health information: (Insert dates of treatment, types of treatment or other designation.)

_____

Date:_____ _____
Patient's Signature

Birth Date:_____ _____
Patient's Name

Patient's Address

Term: This Authorization will remain in effect for one (1) year from the date this authorization is signed.