

Brunswick Gastroenterology Associates, P.A.
121 Medical Center Drive Suite 3400
Brunswick ME 04011
Telephone: (207)725-1355 Fax: (207)729-1457

**Authorization for Release of Information
(to Brunswick Gastroenterology)**

Patient's Name: _____ **Date of Birth:** _____

I hereby authorize _____ (releasing entity) to use or disclose of my protected health information (PHI). I understand that this authorization is voluntary. I understand that my PHI disclosed with this authorization may be subject to re-disclosure by the recipient and may no longer be covered by state and federal laws.

Name of recipient: Brunswick Gastroenterology Associates, P.A.

Address of recipient: 121 Medical Center Drive • Suite 3400 Brunswick ME 04011

Specific description of the information, including dates of healthcare, to be disclosed:

Description of the purpose of authorization:

I understand that my protected health information may contain information on the testing, treatment or diagnosis of HIV (AIDS virus), Psychiatric disorders/ mental health illnesses or alcohol/ drug use. I may request that this information is not disclosed. **DO NOT** release information on _____.

I understand that I may revoke this authorization at any time by providing the releasing entity with a written, signed, and dated request. Should I do so, this action will not have any effect on any actions taken by the providing organization before they received the revocation.

I understand that I may refuse to sign this authorization and that the releasing entity will not condition my treatment upon my signing this authorization. Also, I may inspect or copy the PHI that is the subject of this authorization before the releasing entity discloses the PHI.

I understand that this authorization will remain in effect until _____ (30 mos. from date of signing).

Signature of Patient or Representative

Printed Name

Description of Representative

Date