EL CAMINO GI MEDICAL ASSOCIATES
2490 HOSPITAL DRIVE STE.211
MOUNTAIN VIEW, CA 94040
650-988-7488 PHONE
650-988-7486 FAX

CONSENT TO RELEASE PATIENT RECORD

I hereby authorize ______________________________ to release and
(Name of physician, medical group, hospital)

Disclose information to: ____

____

____
(Name and address where records are to be sent)

Information to be obtained under this authorization includes: _______________

____

Information listed above will be disclosed for the following purpose: _________

____

This authorization is effective until revoked or terminated by the patient or the patient's personal representative.

You may revoke or terminate this authorization by submitting a written revocation to El Camino GI Medical Associates. Information that is disclosed under this authorization may be re-disclosed. The privacy of this information may not be protected under the federal privacy regulations. You may inspect or request a copy of the information that is used or disclosed under this authorization. You may refuse to sign this authorization. You have the right to request us to restrict how we disclose your protected health information for the purposes of treatment, payment, or health care operations.

____
Name of Patient (print) Date of Birth

____
Signature of Patient Date

____
Printed Name & Signature of Patient Representative Date
(only if patient is unable to sign and we have a HIPAA release or POA on file)

The information being sent to the health care provider named is confidential and/or privileged. It is intended to be reviewed by only the individual named above and the information destroyed when no longer needed.