AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION

Patient Name: _____ Date of Birth: _____

Patient Previous Name: _____ Phone Number: ( ) _____

I request and authorize NWGI to release health care information of the above-named patient to:

Name of Medical Office: _____

Address: _____

City, State: _____ Zip: _____

Phone: _____ Fax: _____

Information to be released:

☐ Last Colonoscopy/Endoscopy as well as associated Pathology Results

☐ Last Office Visit Note ☐ Labs and/or imaging results ☐ Other _____

This protected health information is being used or disclosed for the following purpose(s):

_____

This authorization shall be in force and effect until: _____

_____

I understand that, as set forth in NWG/E's Privacy Notice, I have the right to revoke this authorization, in writing, at any time by sending written notification to: Northwest Gastroenterology & Endoscopy
Attn: Privacy Officer
2979 Squalicum Parkway, Suite 301
Bellingham, WA 98225

I understand that until a revocation is in effect, NWG/E has relied on the existing authorization to use or disclose the protected health information.

I understand that once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy Laws may no longer protect it.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Name of Patient or Personal Representative Date

_____
Description of Personal Representative's Authority