FORM - PROTECTED HEALTH INFORMATION Authorization to Release Form

Endoscopy Center of Marin

I, _____, hereby authorize **Endoscopy Center of Marin** (the "Center") to disclose health information regarding the following patient:

Patient Name: _____ Date of Birth: _____
Address: _____ Patient's Phone: _____
_____

1. The information is to be disclosed to the following persons or organizations:
   Name:_____
   Address:_____
   _____

2. Purpose. The purpose of the use or disclosure is:
   - ☐ Personal use only
   - ☐ Continuation/ Coordination of Care
   - ☐ Requested for legal purposes
   - ☐ Other:

   _____
   _____

3. Information to be Disclosed. The information to be disclosed includes only those items checked below, with respect to services provided on or around _____ *(insert dates)*:

   The following medical records:

   - ❑ Discharge Instructions
   - ❑ Lab/ Pathology results
   - ❑ Procedure Report

   ☐ The following billing and payment information:

   _____

   _____

   ☐ Other information:

   _____

4. Revocation. I understand that I may revoke this authorization at any time by sending a written notice to the Center. However, the revocation will not have any effect on any uses or disclosures the Center may have made before the revocation was received.

5. Expiration. I understand that unless I revoke the authorization earlier, this authorization will automatically expire six (6) calendar months after the date this authorization is signed.

6. Redisclosure. I understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be redisclosed by the receiving party.

7. Refusal to Sign. I understand that I may refuse to sign this Authorization and that the Center will not condition treatment on

whether I sign this Authorization.

8. Certification. I certify that I am *(check whichever applies)*:

☐ the patient, and the identification that I have provided is true and correct.
☐ the patient's authorized representative, and that the identification and proof of authority that I have provided are true and correct. My relationship to the patient is that of _____.

Signed this _____ day of _____, 201__.

_____

Signature: (Must match signature on record)

_____

Print name:

_____

_____

_____

Address: (Must match address on record)

Phone No:

_____

WHEN COMPLETED FORMM CAN BE MAILED TO:

ENDOSCOPY CENTER OF MARIN , 1100 S. ELISEO DR. SUITE 3, GREENBRAE, CA 94904

EMAILED TO:

MEDICALRECORDS@ECMARIN.COM

FAXED TO:

415-324-8261

(ONE COPY TO BE RETAINED BY THE REQUESTING PARTY)

_ _

For Office Use Only:

Date received: _____ Expiration date: _____

How was identity verified? _____ Copy made? ☐ Yes ☐ No

How was authority verified?: _____ Copy made? ☐ Yes ☐ No

By: _____ Title: _____

Date: _____