MATHER GASTROENTEROLOGY
AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient's Name: _____ Date of Birth: _____ / _____ / _____
M D Y

*I authorize the use of disclosure of the above named individual's health information as described below.*
*The type and amount of information to be used or disclosed is as follows:*

**I authorize Mather Gastroenterology, a practice of Harbor View Medical Services, PC, to receive the following information from:**

Facility, Practice, or Physician name: _____

Address: _____

City: _____State: _____ Zip: _____

Phone: _____ Fax: _____

Medical information including: _____

- ALL
- Current medical condition: _____
- Laboratory results from: (date) _____ to (date) _____
- Imaging results from: (date) _____ to (date) _____
- Consultation reports from: (doctors name) _____
- Other: _____

Please send records to:

**Mather Gastroenterology**
**70 North Country Road**
**Suite 101**
**Port Jefferson, NY 11777**
**Ph: (631) 978-7700**
**Fax: (631) 509-5238**

*I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to a staff member of Harbor View Medical Services, PC. I understand that the revocation will not apply to information that has already been released by the authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on termination of care.*

*I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries the potential for an authorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I may contact the office manager at the practice.*

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Print Name of Patient or Legal Guardian If not signed by patient, please indicate relationship