**ULSTER GASTROENTEROLOGY, PLLC**
**Reham El-Shaer, MD**
**301 Hurley Ave. Kingston, NY 12401**
**P: 845-309-7597 F: 845-802-0822**
www.drrehamelshaer.com
Ulstergastro@yahoo.com

**AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

**I hereby authorize the use or disclosure of information from the medical records of:**

Patient Name: ____________________________________________ Date of Birth: _________________

**I authorize the following individual or organization to disclose the above named individual's health information:**

Physician/Clinics Name: ___________________________________________________________________________

Address: ______________________________________________________________________________________

Phone: _______________________________ Fax: ______________________________

**This information may be disclosed to and used by the following individual or organization:**

Physician/Clinics Name: ___________________________________________________________________________

Address: ______________________________________________________________________________________

Phone: _______________________________ Fax: ______________________________

**** THERE IS A .75 CENT CHARGE PER PAGE FOR ANY RECORDS BEING PICKED UP IN PERSON, PAYMENT MUST BE MADE BEFOREHAND, PLEASE ALLOW US 3-5 BUISNESS DAYS FOR RECORDS TO BE AVALIABLE FOR PICK UP ****

For the purpose of:

☐ Permanent Transfer ☐ Referral/Second Opinion ☐ Self ☐ Other__________________

Please release the following: **** PLEASE DO NOT SEND ANY HANDWRITTEN RECORDS ****

☐ Progress Notes ☐ Colonoscopy/Upper Endoscopy Report(s) ☐ Biopsy Report(s) ☐ Imaging Report(s)

☐ Lab Report(s) ☐ ALL RECORDS within the last 5 years ☐ Other (specify): ______________________

___________________________________

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I understand that authorizing the disclosure of this health information is voluntary. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentially rules.

____________________________________ ___________________

Signature of Patient Today's Date

____________________________________

Printed Name of patient

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT: (may apply)

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries in my medical records to prevent my misunderstanding of the information contained in these entries. I will not hold Ulster Gastroenterology, PLLC or its physicians liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_______________________________________ ____________________

Signature of Patient Today's Date

_______________________________________

Printed Name of patient