Gateway Medical

Authorization For Release of Medical Information

_____ _____ _____

(Print Patient Name) *(Patient Date of Birth)* *(Patient ID#)*

I hereby authorize the release of my health information relative to my care and treatment during the period of _____ to _____. My consent to release this health information from my medical records shall continue until I expressly revoke this consent. I authorize Gateway Medical LLC to release or obtain my health information:

_____

(List Specific Information Being Requested)

to or from:

_____

(Name of Person or Name of Other Company)

for the following purpose:

_____

(Intended Use of Information)

I UNDERSTAND:

- ✓ I have the right to revoke this authorization, unless the authorization was required solely to obtain health information as a condition of obtaining insurance coverage.
- ✓ My revocation must be in writing.
- ✓ I may not be refused service if I do not sign this authorization.
- ✓ I will be provided a copy of this signed authorization.
- ✓ My health information is subject to re-disclosure by the recipient and no longer protected.

REQUEST TO RESTRICT USE OR DISCLOSURE OF HEALTH INFORMATION

I request that Gateway Medical LLC restrict its use or disclosure of my health information. I request the following restriction:

_____ _____ _____

(Name of Person or Organization) *(Relationship if Applicable)* *(List Specific Information)*

for the following reason/s: _____.

I understand that, if this requested restriction is accepted, Gateway Medical LLC may not necessarily comply with it if I am (the patient is) in need of emergency treatment.

I authorize the release or restriction as indicated above:

_____ _____

(Patient Signature) *(Date)*

_____ _____ _____

*(Personal Representative)** *(Legal Authority to Act for Patient)** *(Date)*

** If/when applicable*

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