

I understand:

- I may refuse to sign this authorization. Treatment, payment, enrollment or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.
- I may inspect or obtain a copy of the medical information covered by this authorization.
- I understand that may be a fee to obtain copies of medical records except when copies are sent directly to a physician or health care provider due to a referral from Marin Gastroenterology.
- I may revoke the authorization at any time. My revocation must be in writing, signed by me or on my behalf and delivered or faxed to Marin Gastroenterology. My revocation will be effective upon receipt, except where use or disclosure has already occurred in accordance with this authorization.
- I have a right to receive a copy of this authorization upon my request.
- I disclosure of the health information is to someone who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected. California law prohibits recipients of your health information from redisclosing such information except with your written authorization or as specifically required or permitted by law.

Signature: _____ Date: _____
Patient or Personal Representative (Parent/Legal Guardian)

Print Name: _____ Phone #: _____

Address: _____
Street name and number City State Zip Code

If Personal Representative, state relationship: _____

For Office Use Only: