METHODIST ENDOSCOPY CENTER, LLC
MEDICAL RECORDS DISCLOSURE AUTHORIZATION

I,_____ hereby authorize **Methodist Endoscopy Center, LLC** to use or disclose the following protected health information:
(Specifically describe the information to be disclosed, including meaningful descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc.)

_____

_____

The protected health information may be disclosed to: (*Name of person or entity who may receive the information, contact address, or fax number information to be sent to)*

_____

_____

This protected health information is being disclosed for the following purposes: (*List specific purposes. If patient does not choose to provide an explanation indicate information released "at the patient's request")*

_____

_____

This authorization shall be in force until:

- ☐ Date: _____
- ☐ Other: _____

I understand that, as set forth in the Center's Privacy Notice, I may revoke my authorization in writing at any time by sending a written notice to:

Methodist Endoscopy Center, LLC
515 North 162nd Avenue, Suite 201
Omaha, NE 68118
Attn: Privacy Officer

I understand that a revocation is not effective to the extent that the facility has relied on the disclosure of the protected health information.
I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

_____	_____	_____
Name of Patient	Patient Date of Birth	Date

_____	_____
Signature of Patient or Personal Representative	Personal Representative's Authority

_____	_____	_____
Name of Witness	Signature of Witness	