JENNIFER KAUFMAN, ARNP PLLC
LARSEN GASTROENTEROLOGY PLLC
LIVER AND DIGESTIVE DISEASES

AUTHORIZATION TO USE, DISCLOSE & RELEASE PROTECTED HEALTH INFORMATION

Patient Name: **DOB:**

Patient/Representative Name: **Phone:**

I am requesting information from the following facility(s):

Hospital(s) or Provider Name(s) **Clinic(s) or Provider Name(s)**

For the range of dates From: To:

For information related to the following diagnosis or injury:

Information to be disclosed:

- ☑ History & Physical
- ☑ Discharge Summary
- ☑ Operative Report
- ☑ Emergency Department Report
- ☑ Diagnostic Reports (lab, x-ray, EKG, etc.)
- ☑ Progress Notes Other (specify):

I understand and agree that the information below will be disclosed if I place my initials in the applicable space next to the type of information.

- ☐ HIV/AIDS testing/treatment
- ☐ Mental Health specific visits
- ☐ GeneticTesting
- ☐ Drug/Alcohol specific visits

For the purpose of: **Continuation of Care**

To be disclosed to: **Jennifer Kaufman ARNP - Larsen Gastroenterology**

Recipient's Address:	625 6th St	Zip:	99403
City:	Clarkston	State:	WA
Phone:	509 758 2200	Fax:	**509 758 6511**
Email:	Transcription@lewisclarkgihealth.com		

Please send my records via:

- ☑ Email
- ☐ Paper Mail
- ☐ Disc
- ☑ Fax

Patient Signature: **Date:**

Representative Signature: Relation to Patient: