THE GASTROENTEROLOGY GROUP, P.A.

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AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Patient Name: _____Account Number: _____

Address: _____

Date of Birth: _____Phone #: _____

PERSON/ORGANIZATION
PROVIDING INFORMATION: _____

ADDRESS:_____

PHONE #: _____ FAX #: _____

PERSON/ORGANIZATION
RECEIVING INFORMATION:_____

ADDRESS:_____

PHONE #: _____ FAX #: _____

PURPOSE OF DISCLOSURE:

☐ Legal ☐ Insurance ☐ Employer

☐ Further medical care ☐ Personal use ☐ Other (please specify):
_____

DATES OF TREATMENT:

INFORMATION REQUESTED:

☐ Emergency Dept. Record ☐ Discharge summary ☐ EKG/cardiac studies ☐ Entire record

☐ Lab results ☐ History and physical ☐ Physical medicine

☐ Pathology reports ☐ Operative Report ☐ Behavioral health

☐ X-ray/medical imaging ☐ Consultation report ☐ Medication records

I understand that:

- The information in my health record may include information about behavioral or mental health services or treatment for alcohol and drug abuse. It may also include information related to genetic testing, treatment or testing for sexually transmitted disease, HIV or AIDS.
- This authorization is voluntary and I do not need to sign this form to ensure healthcare treatment.
- I may inspect or copy the information used or disclosed under this authorization.
- Once this information is disclosed, it may be redisclosed by the person or organization receiving the information and that information may no longer be protected by federal privacy laws or regulations.
- I have the right to revoke this authorization at any time by notifying the Health Information Management Department in writing. I understand that this revocation will not apply to information that has already been released.
- This authorization will expire in ninety (90) days from the date signed below; or upon the following date, event or condition:_____
_____.

Signature of Patient or Legal Representative_____Date_____

If signed by a legal representative, please indicate relationship to patient: _____

Date received:	Method of disclosure: ____Mail _____Fax _____In person pick-up	Completed by:	Date Completed: