Gastroenterology CONSULTANTS, P.A.

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical records of:

Patient Name:_____ Medical Record #: _____

Date of Birth: _____

I authorize the following individual or organization <u>to disclose</u> the above named individual's health information:

_____ Address/Phone/Fax: _____

This information may be <u>disclosed TO</u> and used by the following individual or organization:

_____ Address/Phone/Fax: _____

For the purpose of: _____

Please release the following:

___ Progress Notes
___ History/Physical Exam
___ Colonoscopy Report(s)
___ Biopsy Report(s)
___ All Records
___ Imaging Reports (From (date) _____ to (date) _____)
___ Lab Result(s) (From (date) _____ to (date) _____)
___ Esophagogastroduodenoscopy Report(s)
___ Other Reports (Specify) _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also contain information about behavioral or mental health services, and treatment for alcohol and drug abuse.

___ **YES**, I consent to the release of this information. ___ **NO**, I do not consent to the release of this information.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition:

_____

_____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentially rules. If I have any questions about disclosure of my health information, I can contact **<u>Nicole LeBoeuf-Alfaro</u>**, Administrative Coordinator.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient (if Legal Representative) Witness

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT: (May apply)

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical records to prevent my misunderstanding of the information contained in these entries. I will not hold Gastroenterology Consultants, P.A. or its physicians liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_____ _____
Signature of Patients or Legal Representative Date

_____ _____
Relationship to Patient (if Legal Representative) Witness