Gastroenterology Associates

Gastroenterology and Hepatology
olygastro.com

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient Name _____
Last First Middle Maiden

Address _____
Street Apt # City State Zip

Phone _____ Date of Birth _____

By signing this authorization, I authorize the use or disclosure of my health care information.

I AM REQUESTING THIS INFORMATION FOR:

☐ Personal Use ☐ Legal Use ☐ Transferring care ☐ Insurance
☐ Dissatisfaction with care ☐ Continuing care ☐ Other, reason _____
☐ Appealing the denial of federal Supplemental Security Income or Social Security Disability Benefits

NOTE: A charge may be incurred for copies being provided for legal, insurance, personal use, and in some instances the "other" category.

Once Protected Health Information is released by Gastroenterology Associates, it cannot be guaranteed that the recipient will not disclose the information to a third party. The third party may not be required to abide by this authorization or applicable federal and state law governing the use and disclosure of health information. I understand that I do not have to sign this form to receive health care benefits.

PLEASE CHECK ONE:

☐ Health Care Information relating to the following treatment(s), condition(s) or dates of treatment(s) _____

☐ Last two (2) years of pertinent health care information only (i.e., consults, labs, x-rays, etc.) _____

PLEASE CHECK ONE:

Your facility ☐ ***is*** / ☐ ***is not*** authorized to release any health care information relating to the: **testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or treatment of drug and/or alcohol abuse.**

Health care information to be disclosed from:		**Health care information to be disclosed to:**	
Person/Organization/Facility		Person/Organization/Facility	
Address		Address	
City/State/Zip		City/State/Zip	
Fax	Phone	Fax	Phone

This authorization ends:

☐ On (date): _____ ☐ When the following event occurs: _____

I release Gastroenterology Associates and its staff from all legal responsibility or liability that may arise from the release of information. I understand that I may revoke this consent, in writing, at any time, except when action has already been taken.

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed name, if signed on behalf of patient Relationship (legal guardian, personal representative, parent)