# Gastroenterology Associates

*Gastroenterology and Hepatology*

olygastro.com

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## 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)