Specialists In Gastroenterology

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HIPAA AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

NAME: _____
Last First MI

DATE OF BIRTH: _____-_____-_____ FORMER NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

I hereby authorize:

NAME: _____

ADDRESS:_____

CITY, STATE, ZIP: _____

PHONE: _____

FAX: _____

To disclose my protected health information as indicated below to:

NAME: _____

ADDRESS:_____

CITY, STATE, ZIP: _____

PHONE: _____

FAX: _____

INFORMATION TO BE RELEASED:

- ☐ **Standard Record Release**
  Records within the last 2 years
- ☐ **Any and All Records**
  Includes records prior to the past 2 years
- ☐ **Discharge Summary**
- ☐ **History & Physical Exam**
- ☐ **Progress Notes**
- ☐ **Medication Records**
- ☐ **Detailed Bill**
- ☐ **Consult Notes**
- ☐ **Lab Reports**
- ☐ **X-Ray Reports**
- ☐ **Other (specify content and dates):**
  _____

I specifically authorize the release of information relating to:

Substance abuse (i.e. drug/alcohol abuse)
Mental Health or behavioral health
HIV related information

x_____
Signature of Patient

PURPOSE OF DISCLOSURE:

- ☐ **Changing Physicians**
- ☐ **At request of individual**
- ☐ **Consultation**
- ☐ **Continuation of care**
- ☐ **Other (specify):**
  _____

ACKNOWLEDGEMENT OF UNDERSTANDING:

I understand that by authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care. A photocopy or fax of this authorization is as valid as the original. I may revoke this authorization at any time, except where information has already been release. I understand the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy regulation. I understand that I may see and copy the information described on this form if I ask for it, and that I may obtain a copy of this form after I sign it.

PATIENT/LEGAL REPRESENTATIVE SIGNATURE:

_____ **DATE:** _____