

# 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: \_\_\_\_\_