Gastroenterology Consultants, P.C.

Specialists in Digestive and Liver Diseases

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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the Practice to disclose the following information from the health records of:

Last name: _____First name: _____MI: ____

Birth date: _____Telephone (H)_____(W)_____

Address: _____

City: _____ State: _____ Zip Code: _____

This information may be disclosed to: _____

Covering (Date of service): From (date) _____to (date) _____

For the purpose of: _____

The following information may be released:_____

I understand that this will include information relating to, if applicable:

* **Acquired immunodeficiency syndrome (AIDS) human immunodeficiency virus (HIV) infection.**

* **Behavioral health service/psychiatric care.**

* **Treatment for alcohol and/or drug abuse.**

Affirmation of Release: I give Gastroenterology Consultants, P.C. permission to release only the information I have named and only for the purposes I have checked. I understand that this release is valid up to one year from the date I sign it and I may refuse to sign this authorization or revoke this authorization at any time. Any revocation or refusal to sign this authorization will not affect my ability to obtain treatment or payment or my eligibility for benefits. The revocation will take effect on the day it is received in writing. As a patient I have the right to access my treatment records. Copies of the records may be obtained with reasonable notice and payment of copying cost. I further understand that if the person or entity that receives the above specified information is not a health care provider, health plan or health care clearinghouse covered by the federal privacy regulations or a business associate of these entities, the information described above may be re-disclosed and no longer protected by the regulations.

_____ _____
Signature of the Patient/Guardian/Legal Representative Date Signed

_____
Relationship to Patient

This document expires one year from the date signed.