GASTROENTEROLOGISTS, P.C.

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Foley, Alabama 36535
251-970-1959 Phone
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Patient Information Release Consent Form

PATIENT NAME _____ DOB _____

I have read the privacy policy of Gastroenterologists, P.C., and I understand that Gastroenterologists, P.C., strives to protect my privacy as related to any and all individually identifiable health information concerning me. I do hereby give my permission, and authorize Gastroenterologists, P.C. to release information from my medical record to the following:

- Referring Physician
- Primary Physician
- Consulting Physicians/Hospitals
- Insurance Company
- Any organization required by the law of the country, or the State of Alabama
- Other health care operations in relation to my healthcare treatment
- Listed relatives or other caregivers as defined below. Gastroenterologists, P.C., has my permission to leave a message with any of the below listed persons, or leave a message on my answering machine.

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

CONFIDENTIAL INFORMATION (PLEASE READ EACH ITEM AND MARK APPROPRIATELY)

If the requested portion of the record contains information pertaining to mental health, drug or alcohol treatment, or contains HIV related information, you must specifically authorize the release of such information by initialing one or both of the following:

- I understand that if my record contains information concerning mental health and/or drug and alcohol treatment, such information will be released pursuant to this authorization. Yes ____ No ____

- I understand that if my record contains confidential HIV related information, such information will be released pursuant to this authorization form. Confidential HIV related information is any information indicating that a person had an HIV related test, or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has potentially been exposed to HIV. I understand that I do not have to allow release of HIV related information and that I can change my mind at any time before it is released. Yes ____ No _____

**** This authorization will remain valid until <u>I notify Gastroenterologists, P.C., in writing</u> that I wish to terminate my patient consent for release of personal health information. I understand that I have the right to revoke this authorization at any time.**

_____ **I acknowledge receipt of The HIPAA Notice of Privacy Practices form which details how protected health information may be used and disclosed and how I may access that information. (See HIPAA disclosure)**

_____ _____

Signature of Patient / Representative / or Legal Guardian Date