GASTROENTEROLOGISTS, P.C.

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____ / _____/ _____

1. I authorize the use or disclosure of the above named individual's health information as described below:
2. The following individual or organization is authorized to make the disclosure:

   _____

   _____

   _____

3. The type and amount of information to be disclosed is as follows:

   _____ entire chart

   _____ medication list & list of allergies

   _____ most recent office visit notes

   _____ consultation reports

   ____ most recent discharge summary

   ____ laboratory / pathology reports

   ____ x-ray and imaging reports

   _____ endoscopy procedure reports

   other _____

   Dates needed – from _____ to _____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
5. This information may be disclosed to and used by all physicians at the following organization:

   Gastroenterologists, P.C.
   1625 N. Alston Street
   Foley, AL 36535
   Phone: 251-970-1954
   Fax: 251-970-1960

   I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the office manager. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the privacy officer of Gastroenterologists, P.C., at above listed phone number.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If signed by Legal Representative, Relationship to Patient Signature of Witness