GASTROENTEROLOGY
Associates, PC

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Manassas Office	Administrative / Billing Office	Warrenton Office / Endoscopy Suite	Gainesville Office / Endoscopy Suite
8640 Sudley Rd, Ste 201	8640 Sudley Rd, Ste 207	170 W Shirley Ave, Ste 205	7915 Lake Manassas Dr, Ste 302
Manassas, VA 20110	Manassas, VA 20110	Warrenton, VA 20186	Gainesville, VA 20155
Phone: (703) 368-6819	Phone: (571) 428-2969	Phone: (540) 347-2470	Phone: (571) 248-0653
Fax: (70) 330-2923	Fax: (571) 428-2973	Fax: (540) 349-4683	Fax: (571) 248-0658

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Gastroenterology Associates, PC is authorized by me to use or disclose my Protected Health Information (PHI) for a purpose of treatment, payment, or healthcare operations. I have read this authorization and understand the designated information will be disclosed only to the recipient(s) outlined below. I specifically authorize any current employee or owner of Gastroenterology Associates, PC to disclose the information as outlined. I further understand that I retain the right to revoke this authorization in writing at a later date.

You may disclose the following health information (check all that applies):

_____ Entire Medical Record

_____ Certain Medical Data / Information as related to:
( ) Date of service(s): _____
( ) Specific service(s) or procedure(s): _____
( ) Specific condition(s): _____
( ) Specific medication(s): _____
( ) Other: _____

This authorization permits Gastroenterology Associates, PC to send the protected health information to:

_____

_____

_____

The patient has the right to revoke this authorization in writing. In order for the revocation of this authorization to be effective, Gastroenterology Associates, PC. must receive the revocation in writing by Certified U.S. mail or FAX at this number (540) 349-4683.

This authorization shall expire on _____ or NEVER. After this date, Gastroenterology Associates, PC can no longer use or disclose the patient's protected health information without first obtaining a new authorization form.

I fully understand and accept the terms of this authorization.

_____ _____

Patient or Legal Guardian Signature **Date**