GASTROENTEROLOGY Associates, PC
powered by OneGI

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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**