GASTRO HEALTH

## Authorization for Release of Protected or Privileged Health Information

Used to release copies of health or medical record to patient or to another facility on behalf of the patient, for the patient to request a review of their health medical record and/or to obtain copies of health or medical record from another facility.

Patient Name: _____ Date of Birth:_____

Telephone Contact: _____

I _____do hereby authorize _____
*(Patient Name)* *(Facility Name)*

to release my protected health information including copies of my medical record of care received at the above named facility to the persons or facilities listed below and for the purpose cited below:

**Release Information To:**

- ☐ Self
- ☐ Physician/Facility

Address: _____

**Purpose:** ☐ Medical Care ☐ Personal ☐ Other: _____

**Information to be Released *(Please check all that apply and specify dates)*:**

☐ Entire Record _____ ☐ Clinic Visit Notes _____ ☐ Test Results _____
☐ Letters _____ ☐ Hospital Notes _____

Gastro Health (formerly Digestive Health Specialists) will not release information regarding HTV Test Results, Genetic Screening Test Results, Alcohol and Drug Abuse Records, Psychotherapy, Social Work Counseling/Therapy, Domestic Violence Victims' Counseling or Sexual Assault Counseling without specific written notification from the patient.

**I understand that**

- I may withdraw my authorization at any time and may be withdrawn except to the extent that action has been taken in reliance on ·this authorization.
- I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected, however, the information cannot be released. I will receive a copy of this form after I sign it.
- Information released on this authorization, if redisclosed by the recipient, is no longer protected by Gastro Health (formerly Digestive Health Specialists).
- I understand that the authorization will automatically expire in six months.
- If the information was sent to another person or facility, I understand that I may see and copy the information described on this form if I ask for it.

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of my condition to those persons of agencies listed above.

Patient Signature _____ Date _____

Print Name _____

**When patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required**

Signature of Legal Representative _____ Date _____

Print Name _____ Relation _____