GASTRO HEALTH

www.gastrohealth.com

PATIENT INTERVIEW FORM

PATIENT INFORMATION

First Name: _____ Last Name: _____

Date Of Birth: _____

Race

☐ White/Caucasian ☐ Black or African American ☐ Asian ☐ Hispanic or Latino ☐ American Indian or Alaska Native

☐ Native Hawaiian or Other Pacific Islander ☐ Mixed ☐ Other ☐ Unknown ☐ Patient declines to provide information

Ethnicity

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient declines to provide information

Gender

☐ Male ☐ Female ☐ Other

Preferred Language

☐ English ☐ French ☐ Portuguese ☐ Spanish ☐ Creole ☐ Other: _____

PHARMACY

Name _____ Phone Number _____

CURRENT MEDICATIONS

☐ None

Name	Dose	How Taken?

PAST OR PRESENT MEDICAL CONDITIONS

- [ ] None

- [ ] AICD/Pacemaker
- [ ] Anemia
- [ ] Angina
- [ ] Anxiety Disorder
- [ ] Arthritis
- [ ] Asthma
- [ ] Blood Clots
- [ ] Cancer - Breast
- [ ] Cancer - Colon
- [ ] Cancer - Head/Neck
- [ ] Cancer - Leukemia / Lymphoma
- [ ] Cancer - Lung
- [ ] Cancer - Prostate
- [ ] Cancer - Skin
- [ ] Cancer - Other
- [ ] Celiac Disease
- [ ] Chronic Lung Disease
- [ ] Cirrhosis of Liver
- [ ] Colitis
- [ ] Colon Polyps
- [ ] Crohn's Disease
- [ ] Depression
- [ ] Diabetes
- [ ] Diverticulitis
- [ ] Endometriosis
- [ ] Fatty Liver
- [ ] Fibromyalgia
- [ ] Gallstones
- [ ] Gastroesophageal RefluxDisease (GERD)
- [ ] Glaucoma
- [ ] Heart Failure
- [ ] Helicobacter Pylori
- [ ] Hemorrhoids
- [ ] Hepatitis A
- [ ] Hepatitis B
- [ ] Hepatitis C
- [ ] High Blood Pressure
- [ ] Hepatitis Other
- [ ] Hernia - Abdominal Wall
- [ ] Hernia - Inguinal
- [ ] High Cholesterol
- [ ] High Triglycerides
- [ ] HIV/AIDS
- [ ] Hernia - Umbilical
- [ ] Irritable Bowel Syndrome
- [ ] Kidney Disease/Failure
- [ ] Kidney Stone
- [ ] Lactose Intolerance
- [ ] Lupus
- [ ] Multiple Sclerosis
- [ ] Myocardial Infarction
- [ ] Osteoporosis
- [ ] Ovarian Cyst
- [ ] Pancreatitis
- [ ] Parkinson's
- [ ] Pneumonia
- [ ] Polio
- [ ] Positive PPD
- [ ] Psoriasis
- [ ] Pulmonary Embolus
- [ ] Rheumatic Fever
- [ ] Seizures
- [ ] Sexually Transmitted Disease
- [ ] Sleep Apnea
- [ ] Stomach / Duodenal Ulcer
- [ ] Stroke
- [ ] TB (Tuberculosis)
- [ ] TB Skin Test (Positive)
- [ ] Thyroid Disease
- [ ] Ulcerative Colitis
- [ ] Uterine Fibroids
- [ ] Other: _____

ALLERGIES

- [ ] Patient has no known allergies
- [ ] Patient has no known drug allergies

- [ ] Aspirin
- [ ] Codeine Sulfate
- [ ] Eggs
- [ ] Iodine/Iodine-Containing Products
- [ ] Morphine
- [ ] Penicillins
- [ ] Sulfa (Sulfonamides)
- [ ] Latex
- [ ] Soy
- [ ] Other: _____

DIAGNOSTIC STUDIES / TESTS

- [ ] None

- [ ] Colonoscopy
  When: _____
- [ ] EGD
  When: _____
- [ ] ERCP
  When: _____
- [ ] Liver Biopsy
  When: _____
- [ ] Enteroscopy
  When: _____
- [ ] EUS
  When: _____
- [ ] Capsule Endoscopy
  When: _____
- [ ] Stress Test
  When: _____
- [ ] Echocardiogram
  When: _____

PREVIOUS PROCEDURES

- [ ] None

- [ ] Abdominoplasty Tummy Tuck
  When: _____
- [ ] Appendectomy
  When: _____
- [ ] Bariatric Surgery - Gastric Banding
  When: _____
- [ ] Bariatric Surgery - Gastric Bypass
  When: _____
- [ ] Bariatric surgery - Gastric Sleeve
  When: _____
- [ ] Bladder Surgery
  When: _____
- [ ] Breast
  When: _____
- [ ] C-Section
  When: _____
- [ ] Colon Resection
  When: _____
- [ ] Colostomy
  When: _____
- [ ] Coronary Bypass Surgery
  When: _____
- [ ] Fundoplication Surgery
  When: _____
- [ ] Gallbladder Surgery
  When: _____
- [ ] Hemorrhoid Surgery
  When: _____
- [ ] Hysterectomy Surgery
  When: _____
- [ ] Inguinal Hernia Repair
  When: _____
- [ ] Ovary Surgery
  When: _____
- [ ] Prostate
  When: _____
- [ ] Stomach
  When: _____
- [ ] Thyroid
  When: _____
- [ ] Tubal Ligation
- [ ] Umbilical Hernia Repair
- [ ] Other _____

FAMILY MEDICAL HISTORY

☐ No knowledge of family history

No family history of ☐ Colon Cancer ☐ Crohn's Disease ☐ Ulcerative Colitis ☐ Colon Polyps ☐ Liver Disease

Health Status	Mother	Father	Sister	Brother	Grandmother	Grandfather
Healthy	☐	☐	☐	☐	☐	☐
Deceased / at Age	_____	_____	_____	_____	_____	_____
Diagnoses						
Alcoholism	☐	☐	☐	☐	☐	☐
Bleeding Disorders	☐	☐	☐	☐	☐	☐
Celiac Disease	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐
Colon Polyps	☐	☐	☐	☐	☐	☐
Crohn's Disease	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Heart Trouble	☐	☐	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐	☐	☐
Pancreatic Cancer	☐	☐	☐	☐	☐	☐
Stomach Cancer	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Ulcer Disease	☐	☐	☐	☐	☐	☐

SOCIAL HISTORY

Occupation: _____ Number of Children: _____

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Alcohol

None

☐ Type	Quantity	Number
☐ Rarely		
☐ Less than 2 days/week		
☐ More than 2 days/week		
☐ I quit using		

Tobacco

Smoking Status ☐ Current daily smoker ☐ Current weekly smoker ☐ Former smoker ☐ Never smoker

☐ Smoker, current status unknown ☐ Unknown if ever smoked

Type	Started	Quit	Quantity	Frequency
☐ Cigarettes				
☐ Cigar				
☐ Chewing Tobacco				
☐ Pipe				

Drug Use

☐ None

Type

☐ I have never used recreational drugs ☐ I have used recreational drugs in the past

☐ I am currently using recreational drugs ☐ I have been treated for substance abuse

REVIEW OF SYSTEMS

CONSTITUTIONAL

☐ None	YES	NO
fatigue	☐	☐
fever	☐	☐
night sweats	☐	☐
poor appetite	☐	☐
weight loss	☐	☐
weight gain	☐	☐

ALLERGIC/IMMUNOLOGIC

None	YES	NO
persistent infections	☐	☐

EYES

☐ None	YES	NO
change of vision	☐	☐
eye pain	☐	☐

ENT

☐ None	YES	NO
bleeding gums	☐	☐
hoarseness	☐	☐
mouth sores	☐	☐
nose bleeds	☐	☐
sore throat	☐	☐
change in voice	☐	☐

ENDOCRINE

☐ None	YES	NO
abnormal loss of hair	☐	☐
cold intolerance	☐	☐
excessive thirst	☐	☐

RESPIRATORY

☐ None	YES	NO
cough	☐	☐
shortness of breath	☐	☐
excessive mucus or phlegm	☐	☐
coughing up blood	☐	☐
wheezing	☐	☐

CARDIOVASCULAR

☐ None	YES	NO
chest pain	☐	☐
irregular heart beat	☐	☐
pain in legs when walking	☐	☐
palpitations	☐	☐
swelling in the legs	☐	☐
fainting	☐	☐

GASTROINTESTINAL

☐ None	YES	NO
abdominal pain	☐	☐
abdominal swelling	☐	☐
belching	☐	☐
bloating	☐	☐
blood in stool	☐	☐
change in bowel habits	☐	☐
constipation	☐	☐
diarrhea	☐	☐
gas	☐	☐
heartburn	☐	☐
hemorrhoids	☐	☐
jaundice	☐	☐
nausea	☐	☐
vomiting	☐	☐
poor appetite	☐	☐
rectal bleeding	☐	☐
rectal pain	☐	☐
soiling/incontinence	☐	☐
trouble swallowing	☐	☐

HEMATOLOGIC/LYMPHATIC

☐ None	YES	NO
easy bleeding	☐	☐
enlarged glands	☐	☐
frequent bruising	☐	☐

GENITOURINARY

☐ None	YES	NO
breast enlargement or pain	☐	☐
breast lump	☐	☐
change in urinary frequency	☐	☐
dark urine	☐	☐
decrease in urine flow	☐	☐
painful urination	☐	☐
heavy periods	☐	☐
blood in urine	☐	☐
impotence	☐	☐
urethral discharge	☐	☐
urinary incontinence	☐	☐

MUSCULOSKELETAL

☐ None	YES	NO
back pain	☐	☐
join pain	☐	☐
muscle tenderness	☐	☐
swollen joints	☐	☐

INTEGUMENTARY

☐ None	YES	NO
itching	☐	☐
lesions/nodules	☐	☐
rash	☐	☐
tattoos	☐	☐

NEUROLOGICAL

☐ None	YES	NO
dizziness/lightheadedness	☐	☐
fainting	☐	☐
headaches	☐	☐
numbness/tingling	☐	☐
tremors	☐	☐
weakness in arms	☐	☐
weakness in legs	☐	☐

PSYCHIATRIC

☐ None	YES	NO
abnormal sleep	☐	☐
anxiety/nervousness	☐	☐
depression	☐	☐
hallucinations	☐	☐
memory loss/confusion	☐	☐
panic attacks	☐	☐
suicidal thoughts	☐	☐

IMMUNIZATIONS

☐ None

☐ Flu When: _____

☐ Hepatitis A When: _____

☐ Hepatitis B When: _____

☐ Pneumonia When: _____

☐ HPV When: _____

☐ Shingles When: _____

☐ Tetanus When: _____

☐ Other: When: _____

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information (PHI) may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We may use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your PHI may be provided to a physician to whom you have been referred, DME vendors, surgery centers/hospitals, referring physicians, family practitioner, physical therapists, home health providers, laboratories, worker comp adjusters and nurse case managers, etc. to ensure that the healthcare provider has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay, surgery, MRI or other diagnostic test, injection procedures, injection series, physical therapy, etc., may require that your relevant PHI be disclosed to the health plan to obtain approval for the procedure.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your PHI for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your PHI in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your PHI when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your PHI for marketing purposes. We may not sell your PHI without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your PHI that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request, you have the right to inspect or copy your PHI whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, PHI restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose PHI to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured PHI has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the U.S. Department of Health and Human Service, Office for Civil Rights at (800)368-1019 or OCRMail@hhs.gov if you believe your privacy rights have been violated by Gastro Health, LLC (Gastro Health). Your healthcare services will not be affected by any complaints you make. Gastro Health cannot retaliate against you for filing a complaint, cooperating in an investigation, or refusing to agree to something that you believe to be unlawful. You may file a complaint with us by notifying our Chief Compliance Officer:

Compliance Manager
Gastro Health, LLC - Executive Office
T: 305-913-0682 • F: 305-675-2741
Info@GastroHealth.com

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

CONSENT FOR THE PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I hereby consent to the use or disclosure of my protected health information by Gastro Health, LLC (the "Provider") for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of the Provider. I understand that diagnosis or treatment of me by the Provider may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The Provider is not required to agree to the restrictions that may request. However, if the provider agrees to a restriction that I request, the restriction is binding on the provider and all physicians associated with the Provider.

I have the right to revoke this consent, in writing, at any time, except to the extent the Provider has taken action in reliance on this consent. My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider a healthcare plan, my employer or a health care clearinghouse. This protected health information related to my past, present or future physical or mental health or condition and identifies, or there is a reasonable basis to believe the information may identity me.

I understand I have a right to review the Provider's Notice of Privacy Practices prior to signing this document. The Provider's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Provider. The Notice of Privacy Practices for the Provider is also provided in the waiting room. This Notice of Privacy Practices also describes my rights and the Provider's duties with respect to my protected health information.

The Provider and all physicians associated with the Provider reserve the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Name of Patient or Personal Representative Description of Personal Representative's Authority

DOCUMENTATION OF GOOD FAITH EFFORTS

Patient Name _____ Date _____

The patient presented for treatment on this date and was provided with a copy of the Provider's Notice of Privacy Practices. A good faith effort was made to obtain a written acknowledgement of the receipt of the notice. However, an acknowledgement was not obtained because:

☐ Patient refused to sign.
☐ Patient was unable to sign or initial because:

_____

☐ There was a medical emergency (the Provider will attempt to obtain acknowledgement at the next available opportunity).
☐ Other reason, described below:

_____

_____

Signature of employee completing form:

x _____ Name: _____

GASTRO HEALTH

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities, as that term is defined by HIPAA must obtain a signed authorization from the individual or the individual's legally authorized representative to disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. Individuals cannot be denied treatment based on a failure to sign this authorization form.

NAME OF PATIENT OR INDIVIDUAL

Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month_____ Day _____ Year _____

ADDRESS _____

_____

CITY_____ **STATE** _____ **ZIP** _____

PHONE (____)_____ **ALT. PHONE** (____)_____

EMAIL ADDRESS (Optional):_____

I AUTHORIZE GASTRO HEALTH AND ITS SUBSIDIARIES AND AFFILIATES TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____

Address _____

City _____ State _____ Zip Code _____

Phone (____) _____ Fax (____) _____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION? May we disclose your protected health information to your: spouse, adult children, siblings, attorney, Life Insurance Company or other entity? If yes, Please write their name, contact information and relationship to you.

Person/Organization Name _____

Relationship _____

Address _____

City _____ State _____ Zip Code _____

Phone (____) _____ Fax (____) _____

REASON FOR DISCLOSURE

- ☐ **Treatment/Continuing Medical Care**
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All Health Information**
- ☐ History/Physical Exam
- ☐ Past/Present Medications
- ☐ Lab Results
- ☐ Physician's Orders
- ☐ Patient Allergies
- ☐ Operative Reports
- ☐ Consultation Reports
- ☐ Progress Notes
- ☐ Discharge Summary
- ☐ Diagnostic Test Reports
- ☐ Pathology Reports
- ☐ Billing Information
- ☐ Radiology Reports
- ☐ Imaging Films
- ☐ Other _____

Your initials are required to release the following information:

_____ Mental Health Records (Excluding psychotherapy notes)

_____ Drug, Alcohol, or Substance Abuse Records

_____ Genetic Information (Including Genetic Test Results)

_____ HIV/AIDS Test Results/Treatment

HOW CAN WE COMMUNICATE WITH YOU? Please list the telephone number and/or e-mail address where we can speak to you about your appointments or results.

_____

_____

This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA). Covered entities, as that term is defined by HIPAA, must obtain a signed authorization from the individual or the individual's legally authorized representative to disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. (45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.508)

The authorization provided by use of the form means that the organization, entity or person authorized can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

Definitions - In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual.

Health Information to be Released - If "All Health Information" is selected for release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including:

- Mental health records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501)
- Drug, alcohol, or substance abuse records
- Records or tests relating to HIV/AIDS
- Genetic (inherited) diseases or tests (except as may be prohibited by 45 C.F.R. § 164.502)

Note on Release of Health Records - This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524. However, your provider may use this form for their record keeping in regards to authorized disclosures of protected health information. If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health. (45 C.F.R. § 164.502(a)(1)).

If a healthcare provider is specified in the "Who Can Receive and Use The Health Information" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also includes that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization. Individuals may be entitled to restrict certain disclosures of protected health information related to services paid for in full by the individual (45 C.F.R. § 164.522(a)(1)(vi)).

Authorizations for Sale, Marketing or Research Purposes - If this authorization is being made for sale or marketing purposes and the covered entity will receive direct or indirect remuneration from a third party in connection with the use or disclosure of the individual's information for marketing, the authorization must clearly indicate to the individual that such remuneration is involved. (45 C.F.R. § 164.508(a)(3), (4)).

Limitations of this form - This authorization form shall not be used for the disclosure of any health information as it relates to: (1) health benefits plan enrollment and/or related enrollment determinations (45 C.F.R. § 164.508(b)(4)(ii), .508(c)(2)(ii); (2) psychotherapy notes (45 C.F.R. § 164.508(b)(3)(ii); or for research purposes (45 C.F.R. § 164.508(b)(3)(i)). Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.

Right to Receive Copy – The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.

EFFECTIVE TIME PERIOD: This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional):

Month____ **Day**____ **Year**____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected. If I revoke this Authorization, I must send a written request to: **GASTRO HEALTH, LLC 9500 S. Dadeland Blvd. Suite 200, Miami, FL 33156 ATTN: Privacy Officer**. I understand that the revocation will not apply to information that has already been released in reliance on this Authorization and to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

RESEARCH: I understand that if treatment being provided is related to research for which I have consented to, then my authorization of disclosures for research related purposes is a condition of said treatment. I understand that if I do not sign this authorization, then the Provider will not provide research-related treatment to me.

SIGNATURE AUTHORIZATION: I have read this form and agree to the use and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X _____ _____

Signature of Individual or Individual's Legally Authorized Representative DATE

Printed Name of Legally Authorized Representative (if applicable): _____

If representative, specify relationship to the individual: ☐ Parent of Minor ☐ Guardian ☐ Other_____

SIGNATURE X _____ _____

Signature of Minor Individual DATE

Delivery Method: ☐ Mail ☐ Pickup Date:_____ **Format Requested**: ☐ Paper ☐ CD (Only for Imaging)

Records will automatically be mailed 10 days after pick-up date. (Initial) _____

Charges: In accordance with F.S. 395.3025 licensed Healthcare facilities and ambulatory surgery centers, the fee for medical record copy is: $1.00 search fee for every year requested: $1.00 per page for paper records; $2.00 per page for non-paper records, plus sales tax and actual postage. In accordance with F.S. 456.057 and F.A.C. 64B8-10.003, Healthcare practitioners and physicians' offices charge for medical record copy is: $1.00 per page for the first 25 pages and .25 cents for any page after that. Reasonable costs of reproducing x-rays and such other special kinds of records shall be the actual costs. The phrase "actual costs" means the cost of the material and supplies used to duplicate the record, as well as the labor costs and overhead costs associated with such duplication.

Informed of charge for copies (Please initial) _____