GASTRO HEALTH

Authorization to Use or Disclose Protected Health Information

Patient Name: _____ Date of Birth: _____

Previous Name: _____

I hereby authorize the release of my health information maintained by:

Name of Person or Institution: _____ Phone: _____ Fax: _____

Address: _____

I. My Authorization

You may use or disclose the following health care information (check all that apply):

☐ All health care information in my medical record

☐ Healthcare information in my medical record relating to the following treatment or condition:

_____

☐ Health care information in my medical record for the date(s): _____

☐ Other (e.g., X rays, bills) specify date(s): _____

You may use or disclose health care information regarding testing, diagnosis and treatment for (check all that apply):

☐ HIV (AIDS virus)

☐ Sexually transmitted diseases

☐ Psychiatric disorders/mental health

☐ Drug and/or alcohol use

You may disclose this health care information to:

Name of Physician or Institution: _____ Phone: _____ Fax: _____

Address: _____

Reason(s) for this authorization (check all that apply):

☐ At my request

☐ Other (specify):

_____

☐ Check only if Gastro Health requests the authorization for marketing purposes.

☐ Check only if Gastro Health will be paid or get something of value for providing health information for marketing purposes.

This authorization ends:

This document does not permit disclosure of health information created more than 90 days after the date it is signed.

☐ In 90 days from the date signed

☐ on (date): _____

☐ When the following event occurs: _____

(no longer than 90 days from date signed)

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study or
- To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by Gastro Health based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available at the front desk, or
- Write a letter to the attention of the Privacy Officer, Gastro Health.

Once health care information is disclosed, the person or organization that receives it might re-disclose it. Privacy laws no longer protect it.

_____ _____

Patient or legally authorized individual signature | Date Time

_____ _____

Printed name if signed on behalf of patient | Relationship to patient (parent, legal guardian, personal representative)