GASTRO HEALTH

PLACE PATIENT LABEL HERE

AUTHORIZATION FOR COMMUNICATION OF PROTECTED HEALTH INFORMATION TO FAMILY MEMBERS AND FRIENDS

PART A

By signing below I authorize **Gastro Health** to discuss/share Protected Health Information about me with the following individual(s) who are involved in my care.

Name:	Relationship:	Phone number:
Name:	Relationship:	Phone number:
Name:	Relationship:	Phone number:

Type of information to be disclosed:

☐ Appointment and/or billing information only
☐ ALL information

(Use an additional form if more spaces are needed for additional names)

PART B

I authorize Gastro Health to leave detailed phone messages about my medical information with the following:

☐ Voice mail at the following phone numbers (check any that apply) Home___ Cell___ Work___

Home #_____ Cell #_____ Work #_____

☐ Anyone who answers

This authorization shall remain in effect until revoked in writing by the patient. Submitting a new form will revoke existing form.

_____ _____

SIGNATURE OF PATIENT/AUTHORIZED INDIVIDUAL DATE