# Authorization to Release Health Information

This form allows Gastroenterology Associates to communicate information about your care to you and those you list on this form. It will remain in effect until you end it in writing.

## COMMUNICATING WITH YOU – DETAILED MESSAGES PERMITTED

**Detailed messages may include the following information: (check all that apply)**

☐ All information from this practice ☐ Billing/insurance information ☐ Appointment information only (request/confirm/cancel) ☐ Data breach notifications

Phone #: _____ ☐ Text (SMS)* ☐ Voicemail/answering machine

Other #: _____ ☐ Text (SMS)* ☐ Voicemail/answering machine

EMAIL* _____

*I understand that emails and texts are not always secure ways to communicate and could be intercepted and read by a third party. I am willing to accept this risk. This practice is not responsible for the privacy or security of your health information once it is sent to you, or the recipient(s) listed above.

## COMMUNICATING WITH YOUR FAMILY, FRIENDS, OR CAREGIVERS

This practice may communicate to the family members, friends, or caregivers listed below.

Name: _____ Name: _____

Phone: _____ Phone: _____

Email*: _____ Email*: _____

Relationship: _____ Relationship: _____

**Check the box next to each type of information this practice may share with the individuals listed above.**

☐ All Information ☐ Appointments ☐ Billing/Insurance ☐ Other _____

**PATIENT RIGHTS & SIGNATURE**

- You can end this authorization at any time in writing. See our Notice of Privacy Practices for exceptions. A termination will not apply to any releases of information that happen before we receive a written termination from you.
- You do not have to sign this authorization to receive treatment from this practice.
- All changes or updates to this form must be made in writing and signed by you (patient) or your personal representative. Minor edits can be made on this form, initialed, and date instead of requiring a new form.
- This practice is not responsible for the privacy or security of your health information after it is sent to those listed on this authorization.

X _____ _____

Signature of Patient/Authorized Representative Date

_____ _____

Print Name Patient Date of Birth

(Attach documentation to support the personal representative's authority if not already on file with the practice)