Authorization to Release Health Information

Communications between Patients and their Families, Friends, or Caregivers

GASTROENTEROLOGY ASSOCIATES

This form allows **Gastroenterology Associates** to communicate information about your care to you and those you list on this form.

Patient Name: _____ **Date of Birth:** _____

Main Contact Number: _____ ☐ Home ☐ Cell* ☐ Work

COMMUNICATING WITH YOU

Detailed messages regarding results or protected health information are permitted by: ***(check all that apply)***

☐ Text (SMS)* ☐ Main Contact Number Above ☐ Voicemail ☐ None

☐ Other Contact Number: _____

* 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

Gastroenterology Associates may communicate with the individuals listed below:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Check the box to each type of information we **CAN** share with the individuals listed above:

☐ All information ☐ Prescriptions ☐ Appointments ☐ Billing/Insurance

☐ Other: _____

Do not include:

☐ Mental health records ☐ Alcohol/drug treatment ☐ Communicable diseases

PATIENT RIGHTS & SIGNATURE

- This Authorization will remain in effect until the patient completes and submits a new Authorization form that supersedes this one. The patient may revoke or modify this Authorization at any time, provided that the revocation or modification is in writing and delivered to our practice. See our Notice of Privacy Practices for exceptions. A termination will not apply to any release of information that happens before we receive a written termination from you.
- The recipient of the information could use or release it in a way that federal or state laws do not protect. This practice is not responsible for the privacy or security of your health information after it is sent to those listed on this authorization.
- You can review or copy the information that will be used or released as described in this authorization.
- You do not have to sign this authorization to receive treatment from this practice.
- You understand that the information that will be used or released might include communicable disease diagnosis such as HIV or a diagnosis related to mental health or substance abuse unless you exclude it above.
- 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 dated instead of requiring a new form.
- The Notice of Privacy Practices was made available for my review, and I understand my privacy rights.

_____ _____

Patient/Personal Representative Signature **Date**

Printed name and description of Personal Representative's authority (e.g., healthcare power of attorney): _____

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