AUTHORIZATION TO RELEASE OR OBTAIN HEALTH INFORMATION

This form permits **Gastroenterology Associates** to use and/or release the patient's health information for the purpose(s) described below.

Patient Name: ______________________ **Date of Birth:** ______________
Main Contact Numbers: ______________________ ☐ Home ☐ Cell ☐ Work

RECIPIENT(S): check the appropriate box for GA to obtain and/or release information

☐ I authorize Gastroenterology Associates to **disclose/release information to:**
☐ I authorize Gastroenterology Associates to **obtain information from:**

Practice/Provider: ______________________________

Address, City, State, Zip: ______________________________

Contact Person/Department: ______________ Phone: ______________ Fax: ______________

When releasing records to GA, send records to: 125 Halton Rd Suite 200 Greenville SC 29607 Fax: 864-451-5180

CHECK THE TYPE OF INFORMATION TO BE RELEASED AND/OR OBTAINED:

☐ Entire record
☐ Billing/insurance records
☐ Records from __________ to __________
☐ Lab/diagnostic results related to: ______________
☐ Office visit notes
☐ Clinical images
☐ Other (describe): ______________________

Do not include:

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

Purpose of Release: (check one) ☐ Patient Request ☐ Continuing Care ☐ Transfer of Care ☐ Other ☐ Insurance ☐ Disability ☐ Legal

Format/Delivery (if a release of records) ☐ Paper/Mail ☐ USB/CD-ROM ☐ Fax ☐ Email: ______________________

Requests for information to be released to third parties must be sent in a secure manner.
When a request for medical information involves more than making copies of existing documents, fees may apply.

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 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 a 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.

______________________________ ______________
Patient or 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.

Office Use Only

Date release sent to patient/facility:		Release sent by:	
Date release received by office:		Release given to:	
Date records released:		Records completed and sent by:	