Gastroenterology Associates
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Authorization to Release and/or Obtain Protected Health Information (PHI)

This form permits **Gastroenterology Associates** to obtain and/or release the patient's health information for the purpose(s) described below. Please complete all sections. Incomplete forms may delay processing.

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

Address: _____ **Phone Number:** _____

TYPE OF REQUEST:

☐ **OBTAIN PHI** from another party to be sent to **Gastroenterology Associates**
☐ **RELEASE PHI** from **Gastroenterology Associates** to another party

RECIPIENT/SENDER: This practice may SEND / RECEIVE the information checked below to the following person or entity for the purpose(s) listed on this form.

Name/Organization: _____ Phone: _____

Address: _____ Fax: _____

INFORMATION TO BE OBTAINED AND/OR RELEASED:

Date range of records: From: _____ To: _____ ☐ All dates/Entire record

Select record types (check all that apply):

☐ Entire record ☐ Procedure Notes ☐ Office Visit Notes ☐ Pathology Reports
☐ Laboratory Reports ☐ Billing/Claims Information ☐ Other (specify): _____

Do not include: ☐ Mental health records ☐ Communicable diseases ☐ Substance abuse

DELIVERY METHOD *(if released)*:

☐ Fax (most common) ☐ Pick up in person
☐ Mail ☐ Other: _____

When a request for medical information involves more than making copies of existing documents, fees may apply.

PURPOSE OF DISCLOSURE *(optional)*:

☐ Personal use ☐ Insurance ☐ Continuity of care/treatment
☐ Transfer of care ☐ Legal ☐ Other: _____

PATIENT RIGHTS & SIGNATURE

Expiration: This authorization will automatically expire one (1) year from signature date.
Right to revoke: I understand I may revoke this authorization in writing at any time, except to the extent action has already been taken based on it.
Voluntary: I understand signing this authorization is voluntary. My treatment, payment, enrollment, or eligibility for benefits will not be conditioned on signing, unless permitted by law.
Redisclosure: I understand information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA.
Copy: I understand I have the right to receive a copy of this signed authorization.

Patient or Personal Representative Name (print): _____

Patient or Personal Representative Signature: _____ **Date:** ___/___/_____

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