GASTROINTESTINAL ASSOCIATES, L.L.P.

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Medical Records
Patient Authorization to Release Protected Health Information

Patient name: _____ Date of Birth: _____

Address: _____ Social Security: _____

_____ Chart Number: _____

By signing this I authorize the said doctor below to use and/or disclose the specified protected health information listed about me to or for the party or parties listed below.
I authorize the following physicians:_____

_____

To release to (name/address): the specified information listed including dates:

_____ _____

_____ _____

_____ _____

When my protected health information is used or disclosed pursuant to the authorization, it may be subject to re-release by the recipient and may no longer be protected by the federal HIPPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to Gastrointestinal Associates, L.L.P.; 210 Portland Street, Suite 100, Columbia, MO 65201; 573-777-8819 (fax)

NOTE: *GI Associates will not release any information regarding history of illness or diagnostic and therapeutic information, including any treatment for counseling and/or psychiatric consultation, alcohol, drug abuse, Acquired Immune Deficiency Syndrome (AIDS) without specific written consent from the patient and/or the legal guardian.*

Initial to approve release of said information_____ Date: _____

This authorization is valid until _____/_____/_____, unless revoked in writing prior to this date. If a date is not specified, this authorization will expire in six (6) months.

I hereby acknowledge my authorization to release the above reference patient health information as directed by my instructions.

_____ _____ _____
Signature of Patient or Legal Guardian Relationship to Patient Date

_____ _____
Print Name of Patient or Legal Guardian Witness Signature

Photo identification verified by: _____