

Patient Authorization for Release of Protected Health Information

I hereby authorize the Practice, or any of its employees, staff or agents, to use and disclose health information from the medical record(s) of: *(please print)*

Patient Name: _____ Date of Birth: _____
 Address: _____ Telephone: _____
 City/State/Zip: _____ SSN (last four): _____

RELEASE INFORMATION FROM:

*Specify the name of the
Individual or Organization*

Name: _____
 Address: _____
 City/State/Zip: _____
 Fax: _____

RELEASE INFORMATION TO:

*Specify the name of the
Individual or Organization*

Name: _____
 Address: _____
 City/State/Zip: _____
 Fax: _____

REASON FOR RELEASE:

_____ Continuing Medical Treatment
 _____ Other _____

Type of Information: *(check all that apply)*

Entire Medical Record Dictated Reports Progress Notes
 Lab Results Consultations Procedures
 Nuclear Medicine Referral X-Rays
 Other _____

I acknowledge that data to be release MAY INCLUDE material that is protected by Federal law and that is applicable to either drug/alcohol or mental health information or both. My signature authorizes release of all such information (as specified above and for the purpose mentioned above).

 Patient Signature or Legal Representative Date Relationship, if not patient

 Signature of Witness Date

Right to Revoke: I understand that I may revoke this Authorization t any time except to the extent that action has already been taken in reliance upon it. If I do not revoke it, this Authorization will expire one (1) year after the date on which it was signed. To revoke, I understand I must contact the following in writing: Gastrointestinal Specialists of Georgia, 711 Canton Road Suite 300, Marietta GA 30060.