GI SPECIALISTS OF GEORGIA

Medical Records Fax Number:
678-819-4279

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 released MAY INCLUDE material that is protected by Federal law and that is applicable to specific health statuses, drug / alcohol usage and mental health information. I also understand that once my medical records leave this practice, there is a potential for re-disclosure by the recipient if they are no longer protected by the Privacy Rule.

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 at 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 Rd NE Suite 300, Marietta GA 30060.