AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Usually, we use your Health Information to plan treatment, communicate with your other doctors, or with your insurance company. From time to time, Gastroenterology Associates, PA may wish to use or disclose your protected health information to individuals involved in your care. As stipulated by new Federal Regulations, Title 45, Section 164.510, we need your permission to release your health information to anyone else. BEFORE any employee of Gastroenterology Associates, PA makes any disclosure of any protected health information to a patient's spouse, child, friend, or other third party involved in the patient's care, that employee must verify that Gastroenterology Associates, PA has obtained permission to do so.

Description of the information to be disclosed can be as follows:

1. The patient's entire medical record.
2. The patient's demographic information which includes Name, Address, Telephone, Age, Gender, Insurance, Appointments.
3. The patient's medical data/information as related to: Specific Conditions, Specific Medications, lab results.

At all times the patient has the right to restrict what information is disclosed to any parties, and all employees will abide by any and all restricted restrictions. The patient has the right to revoke this authorization, but this must be done in writing to the attention of our Privacy Officer.
The revocation must include:

1. Patient's name, address, social security number, date of birth
2. The effective date of this authorization and recipients of the protected health information.
3. The date of the revocation and the patient's signature.

Please list any persons and their relationship you authorize Gastroenterology Associates, PA to disclose any of your protected health information to (i.e. family members):

________________________________ ________________________________

________________________________ ________________________________

I fully understand and accept the terms of this authorization. I acknowledge that I have received the "Notice of Privacy Practices" brochure.

Patient Name (please print)	Date of Birth
Signature of Patient	Date

This authorization shall expire on________________________________(typically 2 years). After this date, Gastroenterology Associates, PA can no longer use or disclose the patient's protected health information without first obtaining a new authorization form.

Authorization verified by	Date

Revised 8/14/2017