GASTROENTEROLOGY & HEPATOLOGY ASSOCIATES, PLLC.

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(All sections must be completed)

I hereby authorize Gastroenterology and Hepatology Associates, PLLC. and its physicians, employees, and agents to release to the below-named recipient all of my medical records including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, sexually transmitted disease, or HIV/AIDS infection.

Patient Name: _____ Date of Birth: _____ SSN: _____

Address: _____

I hereby request release of my medical records to:

Name of Facility: _____

Purpose of disclosure: _____

The authorization will expire on: _____(Date or Event may not exceed one year)

This request and authorization applies to: (Check one)

_____ All medical records

_____ Health care information relating to the following treatment, condition, or dates of treatment:

_____

_____ Specific records to be released (eg. Labs, imaging reports, other):

_____

** **If you <u>DO NOT WANT</u> certain portions of your medical records released, please <u>initial</u> beside the information you do not want released. :** _____Substance abuse _____Psychological/psychiatric treatment _____HIV/AIDS/STD

I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

_____ _____

Signature of Patient or Authorized Representative Date Signed

_____ _____

Staff/witness signature Date Signed