Authorization For Disclosure of Patient Health Information (PHI)

Gastroenterology & Nutritional Medical Services, Inc. (Entity)

I, ____ (patient's name) _______________________ (patient's date of birth), ___________________________________ (patient's social security #), hereby authorize the **Gastroenterology & Nutritional Medical Services, Inc.** to **Disclose / Receive** the following protected health information **To / From:**

Name: ____ **Address:** ___________________________________

____ **City, State, Zip:** ___________________________________

Please √ to specifically authorize the use and/or disclosure of:

____History & Physical ____Progress Notes ____Consultation Report ____Laboratory Reports
____Discharge Summary ____Nurses Notes ____Billing Statements ____Pathology Reports
____X-Ray Reports ____Procedure Notes ____Medication History
____Other: ____

This protected health information is being used or disclosed for the following purposes:
____Continuing Medical Care ____Personal Use ____Legal Purposes ____Other_________________________________

This authorization shall be in force and effect until _______________ (date) at which time this authorization to disclose this protected health care information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to the Entity. I understand that a revocation is not effective:
To the extent that this Health Care Provider has relied on the use or disclosure of the protected health information; or if the authorization is obtained as a condition of obtaining insurance coverage, if some other law or the policy itself provides the insurer with the right to contest a claim under the policy.

I hereby authorize Entity to obtain/release the health information indicated above that is contained in my patient records to the Recipient named above. **I understand that this may include treatment for physical and mental illness, alcohol/drug abuse, and or HIV/AIDS test results or diagnoses. This authorization does not include permission to release outpatient Psychotherapy Notes. The release of Psychotherapy Notes requires a separate authorization. Psychotherapy Notes are defined as notes that document private, joint, or family counseling sessions that are separated from the rest of a patient's medical record.**

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I understand that the Entity may not condition my treatment, payment, enrollment in a health plan, or eligibility (if applicable) on whether I provide this authorization for the requested use or disclosure.

I understand that I have the right to:
Inspect or copy the protected health information to be used or disclosed as permitted under federal law, or state law to the extent the state law provides greater access rights; and
Refuse to sign this authorization.

____________________________________ ________________________________
Signature of Patient or Representative** Date

____________________________________ ________________________________
Description of Representative's Authority Witness

If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative **MUST accompany the request (i.e. court appointed guardian, durable power of attorney for healthcare). For a deceased patient: A death certificate coupled with executor or administrator of estate paperwork must accompany authorization. Exception: parent signing for patient under the age of 18.

**For a deceased patient, a court entry or order appointing a fiduciary, executor, or administrator or letters of appointment received from Probate Court must accompany an authorization signed by the named individual. If the estate has not been probated, a death certificate is required coupled with the documents naming the administrator or executor of the estate.

A copy of this document must be provided to the patient when executed.

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